

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11000

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County AlleghenyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 50 yrs

Hospital, institution, or street address where death occurred:

444 Pennsylvania Ave

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County AlleghenyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)Street No. 444 Pennsylvania Avenue  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

George Edward Ambrose

## 3. (b) Social Security Number

None4. Sex Male5. Color or race white6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Setha Pirbey6. (c) If alive, give age 61 years7. Birth date of deceased (mo., day, yr.) Aug 11, 18778. AGE: Years 71 Months 2 Days 26 If less than one day  
hrs. min.9. Birthplace Great Cacapon, Morgan Co. W. Va.  
(Town, county and state)10. Usual occupation Carpenter11. Industry or business Self Employed12. Name Arson Ambrose13. Birthplace Great Cacapon W. Va.14. Maiden name Ellen Steinbaugh15. Birthplace Great Cacapon W. Va.16. Informant Conford AmbroseAddress 939 Ind Ave - Cumb. Md.17. Burial Date thereof Nov 10, 1948  
(Burial, cremation, or removal-Which?) (month) (day) (year)Cemetery or crematory Willcrest CemeteryLocation Cumberland Md.18. Funeral director John J. StaleyAddress Cumberland Md.19. Nov 10, 48 W. F. Fautz, M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 7, 1948 at 11 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 7 19 48and that I last saw him alive on Nov. 7 19 48Immediate cause of death Carcinoma of Rectum

## DURATION

3 yrsDue to Carcinomatous

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma RectumDate of op. Nov. 1947

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

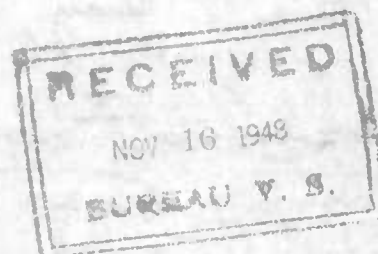
Means of injury Injured at work?

23. SIGNATURE Clay J. FautzM. D. or other CumberlandAddress Date signed 11/8/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



*Amey*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 6

## 1. PLACE OF DEATH:

County Allegany  
 City or town BARTON  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 71 years  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany  
 City or town Barton  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Dominic Watson Arnold

## 3. (b) Social Security Number

214-07-2173

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6.(a) Single, married, widowed, or divorced <u>Single</u>
6.(b) Name of husband or wife _____		
7. Birth date of deceased (mo., day, yr.) <u>October 1, 1777</u>		
8. AGE: Years Months Days It less than one day <u>71</u> <u>1</u> <u>0</u> _____ hrs. _____ min.		
9. Birthplace <u>Barton, Allegany, Maryland</u> (Town, county, and state)		
10. Usual occupation <u>Electrician</u>		
11. Industry or business <u>Delaware Corp of America</u>		
12. Name <u>Dominic Arnold</u>		
13. Birthplace <u>Pennsylvania</u>		
14. Maiden name <u>Ellen Michaels</u>		
15. Birthplace <u>Germantown, Md</u>		
16. Informant <u>Harmore Arnold</u>		
Address <u>Barton, Maryland</u>		
17. <u>Burial</u> Date thereof <u>Nov 4, 1948</u> (Burial, cremation, or removal. Which?) (month) (day) (year)		
Cemetery or crematory <u>St Gabriel Cemetery</u>		
Location <u>Barton, Md</u>		
18. Funeral director <u>Ellsworth St Paul</u>		
Address <u>Hustertown, Md</u>		
19. <u>Nov. 4</u> 19 <u>48</u> (Date rec'd by registrar)		

## MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 1 19 48 at 7:30 P.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1 19 48 to Nov. 1 19 48 and that I last saw him alive on Nov. 1 19 48.  
 Immediate cause of death Pulmonary Edema  
 Due to Chronic Myocarditis and Myocardial Degeneration not specified as rheumatic  
 DURATION 1 Day  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 8 months of death)  
 Major findings of operations None  
 Autopsy results None  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

## 23. SIGNATURE

Paul R Wilson, M.D.  
Piedmont, W.Va  
 Address \_\_\_\_\_ Date signed 11-3-48

Registrar





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11002

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County Allegany  
 City or town Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution?

3 Days

## 3. (a) FULL NAME

Baby Boy Ault

## 3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Infant

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Nov. 14, 1948

8. AGE:

Years

Months

Days

If less than one day

003

hrs.

min.

9. Birthplace

Cumberland, Md.

(Town, county, and state)

10. Usual occupation

Infant

11. Industry or business

FATHER  
MOTHER

12. Name

Eugene R. Ault

13. Birthplace

W. Va.

14. Maiden name

Wilda McDonald

15. Birthplace

W. Va.

16. Informant

Mrs. Garner McDonald

Address

R.D.#1 Box 12 Burlington, W. Va.

17.

BurialDate thereof Nov. 18, 1948  
(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Beaver Run Cem.

Location

Near Burlington, W. Va.

18. Funeral director

Charles L. George

Address

Cumberland, Md.

19.

Nov. 18, 1948  
(Date rec'd by registrar)W. A. Ault, M.D.  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State West Va. County MineralCity or town Rural Keyser  
(If outside city or town limits, write RURAL and give nearest town)Street No. R.D.# 1.  
(If rural, give LOCATION)

2. (a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 17, 1948 at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

14 Nov. 1948 to 17 Nov. 1948and that I last saw him alive on 17 Nov. 1948

Immediate cause of death

Respiratory Failure

DURATION

Due to

Prematurity 6 1/2 mo.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. A. Ault, M.D. M. D. or otherAddress Date signed 17 Nov. 1948

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

**RECEIVED**

NOV 23 1948

**BUREAU V. S.**

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 46f

11003

### 1. PLACE OF DEATH:

County Allegheny  
City or town Frostburg  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 1 month  
Hospital, institution, or street address where death occurred:  
Miner's Hospital  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State MD County Allegheny  
City or town Frostburg  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 59 Berry St.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

John Ball

### 3. (b) Social Security Number

216-10-6826A

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
6.(b) Name of husband or wife Elizabeth Thomas  
7. Birth date of deceased (mo., day, yr.) Aug 15 - 1879 6.(c) If alive, give age 66 years  
8. AGE: Years 69 Months 2 Days 22 If less than one day  
hrs. min.

9. Birthplace England  
(Town, county, and state)

10. Usual occupation Painter

11. Industry or business Glause Corp.

12. Name Unknown

13. Birthplace England

14. Maiden name Unknown

15. Birthplace England

16. Informant Mr. Charles F. Bishop

Address 59 Berry St. Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof 11-9-1948  
(month) (day) (year)

Cemetery or crematory Wheatfield Cemetery

Location Cumtose, Md.

18. Funeral director Jacob Gable

Address Frostburg, Md.

19. 11-9 48 Mr. Nancy K. Roe  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 10-7-1948 19 48 at 3:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

10-12 19 48 to 11-6 19 48

and that I last saw him alive on 11-6 19 48

Immediate cause of death Circulatory failure

DURATION 2 days

Due to Cancer of the liver

2 years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. B. Wolfe M.D.

Address Frostburg Date signed 11-8-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
NOV 11 1948  
BUREAU A. B.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11004

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany  
City or town Rural Cumberland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
R.D.#4 Mexico Farms  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Allegany  
City or town Rural Cumberland  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. R.D.# 4 Mexico Farms  
(If rural, give LOCATION)  
2.(a) If veteran, name war

3. (a) FULL NAME

Sarah Catherine Barrett

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed  
6. (b) Name of husband or wife George Barrett  
6. (c) If alive, give age years  
7. Birth date of deceased (mo., day, yr.) May 28, 1852  
8. AGE: Years 96 Months 5 Days 21 It less than one day hrs. min.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19, 1948 at 11:30 AM  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 15, 1948 to Nov 19, 1948  
and that I last saw alive on 19

Immediate cause of death Infinitive of Age DURATION 2 yrs

9. Birthplace Aquia Creek, Va.  
(Town, county, and state)  
10. Usual occupation Housewife  
11. Industry or business  
12. Name Henry Garrison  
13. Birthplace Va.  
14. Maiden name Unknown  
15. Birthplace Unknown

Due to  
Due to  
Other conditions  
(Include pregnancy within 3 months of death)

16. Informant Mr. Roland C. Barrett  
Address Alexandria, Va.  
17. Burial Date thereof Nov. 22, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Oak Wood Cemetery  
Location Falls Church, Va.  
18. Funeral director Charles L. George  
Address Cumberland, Md.

Major findings of operations  
Date of op.  
Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide Date of  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, pub'c place (where?)  
Means of Injury Injured at work?

23. SIGNATURE WES Owens MD M. D. or other  
Address 133 Va Ave Date signed 11/20/48

19. Nov. 21, 1948 W.R. Frank, M.D.  
(Date rec'd by registrar) Registrar

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

RECEIVED

NOV 30 1948

BUREAU V. S.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

11005

Reg. Dist. No. 8

50

## 1. PLACE OF DEATH

County Allegheny  
 City or town Moscow  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 31 years  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution? 1

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegheny  
 City or town Moscow  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war no

## 3. (a) FULL NAME

Blanche M. B. Beaman

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced married  
 6.(b) Name of husband or wife Noah Beaman  
 6.(c) If alive, give age 52 years  
 7. Birth date of deceased (mo., day, yr.) Sept 15, 1891  
 8. AGE: Years 57 Months 1 Days 20 If less than one day  
 hrs. min.

9. Birthplace Romney, W. Va.  
 (Town, county, and state)  
 10. Usual occupation Housework  
 11. Industry or business Own home  
 12. Name Isaac P. Beaman  
 13. Birthplace West Va.  
 14. Maiden name Matilda Beaman  
 15. Birthplace West Va.

16. Informant Noah Beaman  
 Address Moscow, Ind.  
 17. Burial Date thereof Nov. 11, 1948  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Calvary Cemetery  
 Location Moscow, Ind.  
 18. Funeral director Mr. Eichhorn  
 Address Frederick, Md.  
 19. Nov 11 1948 Jessie M. Beal  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8 1948 at 7:45 M.  
 21. I CERTIFY that death occurred on the date above stated, that I attended deceased from  
June 1 1948 to Nov. 8 1948  
 and that I last saw him alive on Nov. 1 1948  
 Immediate cause of death

Generalized Carcinomatous DURATION  
6 mo.  
 Due to Carcinoma of Breast  
removed 1942  
 Due to  
 Other conditions

(Include pregnancy within 3 months of death)  
 Major findings of operations Carcinoma Breast  
 Date of op. 1942  
 Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE E. Berry M.D.  
 Address Fredmont W. Va. M. D. or other  
 Date signed 11/8/48

MARGIN RESERVED FOR BINDING

VS/A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**RECEIVED**

NOV 16 1948

**BUREAU V. S.**

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

11066

Reg. Dist. No. 6

### 1. PLACE OF DEATH:

County Allegany

City or town McCoole  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town McCoole  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 228 Queen Street  
(If rural, give LOCATION)

2. (a) If veteran, name war

### 3. (a) FULL NAME

Samuel Marsh Bean

### 3. (b) Social Security Number

216-07-8452

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Lena Rettenmier

7. Birth date of deceased (mo., day, yr.) Mar 3rd. 1993 6. (c) If alive, give age 66 years

8. AGE: Years 65 Months 8 Days 11 If less than one day hrs. min.

8. Birthplace Elkhorn, Nebraska  
(Town, county, and state)

10. Usual occupation Retired Carpenter

11. Industry or business

12. Name George Bean

13. Birthplace Petersburg, W. Va.

14. Maiden name Frances Allen Marsh

15. Birthplace Nebraska

16. Informant Mrs. Mary Grove Chapman

Address McCoole, Md.

17. Burial 11-16-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Queenspoint

Location Keyser, W. Va.

18. Funeral director N. H. Rogers

Address Keyser, W. Va.

19. Nov. 16 19 48 Keyser, W. Va.  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 14th 19 48, at 5 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from I saw him dead 19 Nov. 14th, 19 48, and that I last saw him alive on 19 Nov. 14th, 19 48.

Immediate cause of death Coronary occlusion due to arterio sclerosis DURATION at once  
Due to Several yrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Deputy Medical Examiner Injured at work? Allegany Co.

H. V. Beming, M.D. 23. SIGNATURE AVD Beming M.D.  
M. D. other

Address Cumberland, Md. Date signed 11-14-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 2 1948

BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11007

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany  
City or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 30 years  
Hospital, institution, or street address where death occurred:  
Allegany Hospital  
How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany  
City or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 505 Linden St.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

3. (a) FULL NAME

MRS. DOVE M. BERG

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
6.(b) Name of husband or wife Oscar F. Berg  
7. Birth date of deceased (mo., day, yr.) April 12, 1883  
8. AGE: Years 65 Months 7 Days 21 If less than one day  
.....hrs. ....min.

9. Birthplace Barbour Co. W. Va.  
(Town, county, and state)  
10. Usual occupation Housewife  
11. Industry or business

12. Name Henry C. Shaffer  
13. Birthplace Tucker Co. W. Va.  
14. Maiden name Serana Phillips  
15. Birthplace Barbour Co. W. Va.

16. Informant Mr. Oscar F. Berg  
Address 505 Linden St. Cumberland, Md.

17. Burial Date thereof Nov. 6, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Hill Crest Burial Park  
Cumberland, Md.  
Location

18. Funeral director William H. Kight  
Address Cumberland, Md.

19. Nov 5, 1948 W. S. Frank, M.D.  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 3, 1948 at 12-55 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Oct. 20, 1948 to Nov. 3, 1948  
and that I last saw him alive on November 3, 1948

Immediate cause of death myocardial infarction DURATION months

Due to Hypertensive C.V. disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide Date of  
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

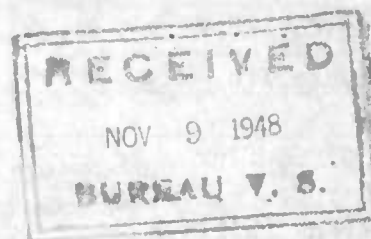
23. SIGNATURE B. M. Schaeffer, M.D. M. D. or other  
Address 41 Ernest Date signed Nov 5, 1948

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

11009

Reg. Dist. No. 6

## 1. PLACE OF DEATH:

County AlleganyCity or town Rural near McCooles  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Rural near McCooles  
(If outside city or town limits, write RURAL and give nearest town)Street No. R.F.D. #3 Keyser, W. Va.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Thomas Anderson Carr

## 3. (b) Social Security Number

214-14-7991

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MaleWhiteMarried6. (b) Name of husband or wife Leota F. Kimble6. (c) If alive, give age 24 years7. Birth date of deceased (mo., day, yr.) Sept. 21, 19248. AGE: Years Months Days If less than one day  
24 2 9 hrs. min.9. Birthplace Red Creek, W. Va.  
(Town, county, and state)

10. Usual occupation

11. Industry or business W. Va. Pulp & Paper Co.FATHER 12. Name Martin Carr  
13. Birthplace Tucker Co. W. Va.MOTHER 14. Maiden name Margaret Carr  
15. Birthplace Tucker Co. W. Va.16. Informant Mrs. Leota F. Carr  
Address R.F.D. #3, Keyser, W. Va.17. Burial Date thereof 12-2-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory WaxlerLocation Near Danville, Md.18. Funeral director Rogers Funeral HomeAddress 85 S. Main St. Keyser, W. Va.19. Dec. 2 1948 Registrar  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 30, 1948 at 2:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

JUNE 3, 1937 to NOV. 30, 1948  
and that I last saw him alive on Nov. 27, 1948Immediate cause of death Uremia due to  
Chronic NephritisDue to Chronic Nephritis

Due to

Other conditions Hypertension

(Include pregnancy within 8 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Paul A. Wilson M.D.

M. D. or other

Address Piedmont, W. Va. Date signed 12-2-48

RECEIVED

DEC 4 1948

BUREAU V. S.

City Limits

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

11010

Reg. Dist. No. 4

### 1. PLACE OF DEATH:

County Allegany  
City or town Near Cumberland Rural  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 40 Years  
Hospital, institution, or street address where death occurred  
Rt 6, Green Point Farms  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Allegany  
City or town Near Cumberland Rural  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Route 6, Green Point Farms  
(If rural, give LOCATION)  
2. (a) If veteran, name war

### 3. (a) FULL NAME

Laura Virginia Clark

### 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow  
6. (b) Name of husband or wife John Clark  
7. Birth date of deceased (mo., day, yr.) March 9 1875  
8. AGE: Years 73 Months 8 Days 19 If less than one day  
hrs. min.

### MEDICAL CERTIFICATION

20. DATE OF DEATH November 28 1948 at 10-30 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
19 to 19

and that I last saw him alive on 19

Immediate cause of death Chronic Cardiac-vascular Renal Disease  
DURATION 5 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John R. Fopper MD M. D. or other

Address Hyndman Pa Date signed 11.29.48

9. Birthplace Barton, Allegany Co, Maryland.  
(Town, county, and state)

10. Usual occupation House

11. Industry or business

12. Name Jacob Schriver

13. Birthplace Unknown

14. Maiden name Eliza Fazenbaker

15. Birthplace Unknown

16. Informant Mrs James Johnson

Address Rt 6, Cumberland, Md.

17. Burial Date thereof 11/30/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Cumberland, Md.

18. Funeral director William H. Kight

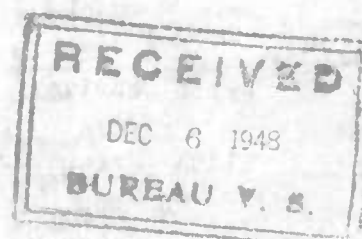
Address Cumberland, Md.

19. Nov. 30 1948 Registrar  
(Date rec'd by registrar)

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1142

11008

## CERTIFICATE OF DEATH

Reg. Dist. No. 8

## 1. PLACE OF DEATH:

County Allegany  
 City or town Marion  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 28 years  
 Hospital, institution, or street address where death occurred: Gettysburg Street  
 How long in hospital or institution? none

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Allegany  
 City or town Marion  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Gettysburg St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war WW

## 3. (a) FULL NAME

James Frederick Clupp

## 3. (b) Social Security Number

179-03-4945

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Fancy Jane C. Clupp 6.(c) If alive, give age 72 years7. Birth date of deceased (mo., day, yr.) May 18, 18748. AGE: Years 74 Months 6 Days 9 If less than one day hrs. min.9. Birthplace Marion, Allegany Co., Md. (Town, county, and state)10. Usual occupation Blacksmith11. Industry or business Maryland Coal Co.12. Name Anthony Clupp13. Birthplace Unknown14. Maiden name Mary Lavinia Haberkamp15. Birthplace Germany16. Informant Miss Pauline BrooksAddress Marion, Md.17. Burial, cremation, or removal, which? Burial Date thereof Nov. 30, 1948 (month) (day) (year)Cemetery or crematory Philos CemeteryLocation Gettysburg, Md.18. Funeral director M. EichhornAddress Marion, Md.19. Nov 30 19 48 Jannette M. Pool Registrar

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH 11 / 26 19 48 at 12:15 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11 / 26 19 48 to 11 / 26 19 48and that I last saw him alive on 11 / 25 19 48Immediate cause of death Pulmonary Hemorrhage DURATIONDue to Ruptured blood vesselDue to CoughingThought to have had the because of chronic cough "lung trouble" a profuse sputumOther conditions had started bleeding orally a day before death but had(Include pregnancy within 3 months of death) refused medical aidMajor findings of operations (12/31/48 45)

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 11 / 26 / 48

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Paul Eugene Dye, M.D. M.D. or otherAddress Marion, Md. Date signed 11 / 29 / 48

MARGIN RESERVED FOR BINDING

9-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**RECEIVED**

DEC 2 1948

BUREAU V. S.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11011

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY  
City or town CUMBERLAND  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 2-DAYS  
Hospital, institution, or street address where death occurred:  
MEMORIAL HOSPITAL  
How long in hospital or institution? 2-DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State MARYLAND County ALLEGANY  
City or town CUMBERLAND  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 417 N CENTRE ST  
(If rural, give LOCATION)  
2.(a) If veteran, name war

3. (a) FULL NAME

EDITH L COLLEY

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

FEMALE WHITE MARRIED

6. (b) Name of husband or wife CHARLES L COLLEY

6. (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) DECEMBER 10, 1891

8. AGE: Years Months Days If less than one day  
56 10 26 hrs. min.

9. Birthplace Maryland, Cumberland, Alleg.  
(Town, county, and state)

10. Usual occupation HOUSEWIFE

11. Industry or business

12. Name JOHN FISHER

13. Birthplace MARYLAND, Cumberland

14. Maiden name KOEGEL, MARY

15. Birthplace MARYLAND, Cumberland

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND MD

17. Burial Date thereof Nov. 17, 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Free Hill Mausoleum

Location Cumberland, Md.

18. Funeral director Tris Steis, Inc.

Address Cumberland, Md.

19. Nov 15 19 48 W. F. WMS Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV. 15 19 48 at 2:40 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/13

19 48 to 11-15 19 48

and that I last saw her on 11-14 19 48

Immediate cause of death Cerebral Hemorrhage

Due to from

Due to 11/12/48

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm. F. Williams

M. D. or other

Address Cumberland Date signed 11/15/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 23 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DR. T. B. HUNTER

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

11612

## 1. PLACE OF DEATH:

County ALLEGANYCity or town CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 DAY

Hospital, institution, or street address where death occurred:

Memorial HospitalHow long in hospital or institution? 1 DAY

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State PENN. County BEDFORDCity or town HYNDMAN  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_ ✓

## 3.(a) FULL NAME

WILLIAM D. COOK

## 3.(b) Social Security Number

4. Sex

MALE

5. Color or race

WHITE

6.(a) Single, married, widowed, or divorced

MARRIED6.(b) Name of husband or wife JESSIE JORDON6.(c) If alive, give age 65 years7. Birth date of deceased (mo., day, yr.) 8-8-838. AGE: Years Months Days If less than one day  
65 3 10 hrs. min.9. Birthplace BEDFORD, PA.  
(Town, county, and state)10. Usual occupation RETIRED ENGINEER11. Industry or business B. & O. R.R.12. Name THEODORE COOK13. Birthplace BEDFORD, PA.14. Maiden name MARY ELLEN TIPTON15. Birthplace PENNSYLVANIA16. Informant MEMORIAL HOSPITALAddress MEMORIAL AVE.17. Burial Date thereof Nov. 21, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Hyndman Cem.Location Hyndman Pa18. Funeral director Johnson and SonAddress Berlin, Penna.19. Nov. 19, 48 W.D. Tautz, M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH NOVEMBER 18 19 48 at 9:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 2 19 48 to Nov 18 19 48and that I last saw him alive on Nov 18 19 48Immediate cause of death Cardio renal

DURATION

Due to apoplexy

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

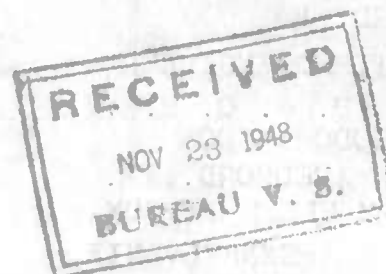
Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE T. Bailey Hunter, M.D.

M. D. or other

Address Cumberland Md Date signed 11/19/48



Within corporate limits

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

11013

## 1. PLACE OF DEATH:

County Allegany  
 City or town Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 28 Years  
 Hospital, institution, or street address where death occurred:  
Allegany Hospital  
 How long in hospital or institution? 3 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany  
 City or town Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Rear 134 Reynolds Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Elma Blanche Cross

## 3. (b) Social Security Number

234-38-7754

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Oscar Cross  
 6.(c) If alive, give age 34 years  
 7. Birth date of deceased (mo., day, yr.) January 15 1914  
 8. AGE: Years 34 Months 10 Days 10 If less than one day hrs. min.

9. Birthplace Flintstone, Allegany Co., Maryland  
 (Town, county, and state)

10. Usual occupation Waitress

11. Industry or business Windsor Restaurant

12. Name Jesse Oneal

13. Birthplace Beans Cove, Pa

14. Maiden name Viola Elliott

15. Birthplace Beans Cove, Pa

16. Informant Oscar Cross

Address Rear 134 Reynolds St, Cumberland, Md.

17. Burial Date thereof 11/28/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hill Crest Cemetery

Location Cumberland, Md.

18. Funeral director William H. Kight

Address Cumberland, Md.

19. Nov. 27, 1948 W.R. Frank, M.D.  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 25 19 48 at 7-45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 22 1948 to Nov 25 1948  
 and that I last saw her alive on Nov 25 1948

Immediate cause of death Perforated gastric ulcer with general peritonitis 4 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations as given under cause of death Date of op. 11-22-48

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James J. Johnson, M.D.  
 Address Cumberland, Md. Date signed 11-26-48

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
NOV 30 1948  
BUREAU U. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH

County.....

City or town.....

(If outside city or town limits, write FULL ADDRESS and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No. ....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex

5. Color of race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

6. (c) If alive, give age ..... years

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

..... hrs. .... min.

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19.

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

1948, at 12:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 18, 1948, to Nov. 21, 1948

and that I last saw her alive on

Nov. 21, 1948

Immediate cause of death

cachexia

DURATION

1 year

Due to

Cancer of Breast

3 years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

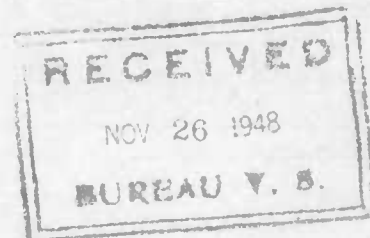
Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County Allegheny  
 City or town Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 22 years  
 Hospital, institution, or street address where death occurred:  
Allegheny Hospital  
 How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Md County Allegheny  
 City or town New Cumberland Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Route 1  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Calvin Edwin Deal

## 3. (b) Social Security Number

None

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Margaret Lenhart  
 6. (c) If alive, give age 74 years  
 7. Birth date of deceased (mo., day, yr.) March 29, 1872  
 8. AGE: Years 76 Months 7 Days 6 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Deal, Somerset Co., Pa.  
 (Town, county, and state)  
 10. Usual occupation Retired  
 11. Industry or business Gas & Oil Dealer  
 12. Name Edwin Deal  
 13. Birthplace Lorimer Twp., Pa.  
 14. Maiden name Nancy Lepley  
 15. Birthplace Lorimer Twp., Pa.  
 16. Informant Harry C. Deal  
 Address Rt. 1, Cumberland, Md.  
 17. Burial Date thereof November 7, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Meyersdale Union Cemetery  
 Location Meyersdale, Pa.  
 18. Funeral director John J. Hoyer  
 Address Chubbards, Md.  
 19. Nov. 6 19 48 W.R. Tantz, MD  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 5 19 48, at 10 45 A.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 3 19 48 to November 5 19 48  
 and that I last saw him live on November 4 19 48  
 Immediate cause of death congestive heart failure  
 Due to arteriosclerotic heart disease  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 9 months of death)  
 Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
 Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_  
 23. SIGNATURE L. Bling M.D. or other \_\_\_\_\_  
 Address 59 S. Main St. Date signed 11-6-48

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

11015

RECEIVED  
NOV 9 1948  
BUREAU V. S.

DR TOPPER

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

11016

## 1. PLACE OF DEATH:

County ALLEGANYCity or town CUMBERLAND  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 18 DAYS

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITALHow long in hospital or institution? 18 DAYS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State BUFFALO MILLS County BEDFORDCity or town PENN.  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_ ✓

## 3. (a) FULL NAME

ELMER S DIVELY

## 3. (b) Social Security Number

4. Sex

MALE

5. Color or race

WHITE

6.(a) Single, married, widowed, or divorced

SINGLE

6.(b) Name of husband or wife \_\_\_\_\_

7. Birth date of deceased (mo., day, yr.)

DEC. 23, 1897

8. AGE: Years Months Days If less than one day

50109hrs.min.9. Birthplace Bedford Penna, Bedford County  
(Town, county, and state)10. Usual occupation KELLY SPRINGFIELD TIRE CO.

11. Industry or business

12. Name DIVELY HENRY13. Birthplace PA14. Maiden name HOCHSETTLER ALICE15. Birthplace PA16. Informant MEMORIAL HOSPITALAddress CUMBERLAND MARYLAND17. Burial Date thereof Nov. 5, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory S.O.O.F.Location Berlin, Pa.18. Funeral director W. J. JohnsonAddress Berlin, Pa.19. Nov. 3, 1948 W. L. Tautz, M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH NOV 2 19 48 at 4:12 P21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/15 19 48and that I last saw him alive on 11/2/48 19 48Immediate cause of death Cancer Stomach DURATION 16 mos

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Major findings of operations \_\_\_\_\_

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE John C. Topper M.D. M. D. or otherAddress Berlin, Pa. Date signed 11.3.48

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## CERTIFICATE OF DEATH

Reg. Dist. No. 93d 11017

## 1. PLACE OF DEATH:

County Allegany  
 City or town McCoole  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 54 years  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Allegany  
 City or town McCoole  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

THOMAS ALFRED DUCKWORTH

## 3. (b) Social Security Number

\*\* None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Minnie Rose Barnard Duckworth  
 6. (c) If alive, give age 80 years

7. Birth date of deceased (mo., day, yr.) June 27, 1869

8. AGE: Years 79 Months 4 Days 22 \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Westernport, Stoney Run, Allegany, Maryland  
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

12. Name Alton C. Duckworth

13. Birthplace Stoney Run, Maryland

14. Maiden name Goldie C. Wilt

15. Birthplace Allegany Co., Maryland

16. Informant Harry Duckworth

Address McCoole, Maryland

17. Burial Nov 21, 1948

(Burial, cremation, or removal, Which?) Date thereof (month) (day) (year)

Cemetery or crematory Philos Cemetery

Location Westernport, Maryland

18. Funeral director Ellsworth S. Boal

Address Westernport, Maryland

19. Nov. 21 1948 George H. Baker M.D.

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 19, 1948 at 9:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 10, 1946 to Nov 19, 1948  
 and that I last saw him alive on Nov. 18, 1948

Immediate cause of death Pulmonary Edema DURATION 1 Day

Due to chronic Myocarditis and Myocardial Degeneration Not Specified as Rheumatic 3 Years

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations None

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results None

PHYSICIAN: Please underwrite the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

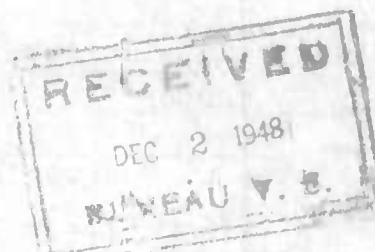
Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Paul R. Wilson M.D.

Address Piedmont, W. Va. M. D. or other \_\_\_\_\_

Date signed 11-20-48







## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11018

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County AlleganyCity or town Cumberland Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 36 yearsHospital, institution, or street address where death occurred:  
106 Polk St.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County AlleganyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)Street No. 106 Polk St.  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

Mrs. Reatha Maud Durr

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Edward A. Durr7. Birth date of deceased (mo., day, yr.) July 27- 1884 1884

8. AGE: Years Months Days If less than one day

64327hrs.min.9. Birthplace Elkins W. Va.  
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Own homeFATHER 12. Name William D. Scott13. Birthplace Elkins W. Va.MOTHER 14. Maiden name Elizabeth Apperson15. Birthplace Richmond Va.16. Informant Mrs. Bernice Little (daughter)Address 106 Polk St. Cumberland Md.17. Burial Date thereof Nov. 27, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Hillcrest Burial ParkLocation Cumberland, Md.18. Funeral director John J. HofusAddress Cumberland, Md.19. Nov. 27, 1948 W. R. Tandy, Md.  
(Date rec'd by registrar) Registrar

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 24 19 48 at 1 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to..... 19.....

and that I last saw h. er Dead Nov. 24 19 48

Immediate cause of death.....

Chronic myocarditis

## DURATION

about 11  
yearsDue to arteriosclerosis with  
hypertention

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

Deputy Medical Examiner - Allegany Co.23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D.  
M. D. or otherAddress Cumberland Md. Date signed 12-24-48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 30 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

### 1. PLACE OF DEATH:

County Allegany

City or town Frostburg, Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about 2 yrs.

Hospital, institution, or street address where death occurred:  
6 Grant St.

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Frostburg Md.  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 6 Grant St.

(If rural, give LOCATION)

2.(a) If veteran, name war World war I

### 3. (a) FULL NAME

Charles K. Dycbe

### 3. (b) Social Security Number

2I4-05-4420

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Thelma Phillips

6. (c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.) February 28, 1901

8. AGE: Years 47 Months 8 Days 27 If less than one day hrs. min.

9. Birthplace Magnolia, W. Va.  
(Town, county, and state)

10. Usual occupation Truck Driver

11. Industry or business Celanese Corp. of Amer.

12. Name James H. Dycbe

13. Birthplace Ori lens, Md.

14. Maiden name Bessie M. Whorrell

15. Birthplace Bard, Pa.

16. Informant Wife

Address 6 Grant St. Frostburg, Md.

17. Burial Date thereof Nov. 28, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Allegany Cem. Frostburg, Md.

Location Frostburg, Md.

18. Funeral director James F. Scarpelli

Address Cumberland, Md.

19. Nov. 27 18 48 Mrs. Nancy V. Roe  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 11-25 19 48 at 3 1/2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-21 19 48 to 11-25 19 48

and that I last saw him alive on 11-23 19 48

Immediate cause of death coronary occlusion DURATION 5 hours

Due to

Due to

Other conditions angina pectoris 2 weeks

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Adolf Weisner M.D. M. D. or other

Address Frostburg, Md. Date signed 11-25-48

MARGIN RESERVED FOR BINDING

V5 A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 30 1943

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 11020 4

## 1. PLACE OF DEATH:

County Allegany  
 City or town Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 6 Hours  
 Hospital, institution, or street address where death occurred:  
Allegany Hospital  
 How long in hospital or institution? 6 hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany  
 City or town Near Cumberland Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Rt 1  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Baby Boy Eaton

## 3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single  
 6. (b) Name of husband or wife  
 7. Birth date of deceased (mo., day, yr.) November 22 1948  
 8. AGE: Years Months Days If less than one day  
6 hrs. min.

9. Birthplace Cumberland, Allegany Co., Maryland  
 (Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Earl F. Eaton  
 13. Birthplace Cumberland, Md.  
 14. Maiden name Stella Yancenech  
 15. Birthplace Preston, W. Va.

16. Informant Earl F. Eaton  
 Address Rt 1, Cumberland, Md.

17. Burial Date thereof 11/24/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Hill Crest Cemetery  
 Location Cumberland, Md.

18. Funeral director William H. Knight  
 Address Cumberland, Md.

19. Nov. 24 19 48 W. H. Knight, M.D.  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 22 19 48 at 8 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 22 19 48 to Nov. 22 19 48  
 and that I last saw him alive on Nov. 22 19 48

Immediate cause of death Posttraumatic hemorrhage DURATION 6 hours

Due to Birth injury

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

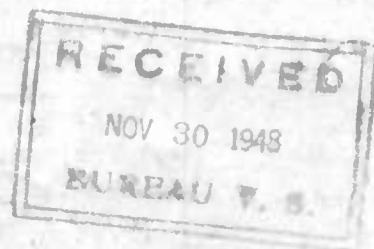
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. M. M.D. M. D. or other

Address 55 Green St. Date signed 11-23-48



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

11021

## 1. PLACE OF DEATH:

County AlleganyCity or town Cumberland Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? about 5 minutes

Hospital, institution, or street address where death occurred:

Corner of Williams & Baker St.How long in hospital or institution? Dead on arrival, Memorial

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County AlleganyCity or town Near Cumberland Rural  
(If outside city or town limits, write RURAL and give nearest town)Street No. R.F.D. Williams Rd.  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

Robert Immanuel Eshbaugh

## 3. (b) Social Security Number

214-05-6537

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife Damie Liller Eshbaugh6. (c) If alive, give age 65 years

7. Birth date of

deceased (mo., day, yr.) July 28-1882

8. AGE:

Years

Months

Days

If less than one day

66313

hrs.

min.

9. Birthplace Jefferson Co. Pa.  
(Town, county, and state)10. Usual occupation Labor

11. Industry or business

B. & O R.R.

FATHER

12. Name David Allen Eshbaugh

13. Birthplace

unknown

MOTHER

14. Maiden name Elizabeth Catherine Bailey

15. Birthplace

unknown16. Informant Mrs Walter HouserAddress 124 Arch St.17. Burial Date thereof Nov. 15, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Davis Memorial Cem.Location Cumberland, Md.18. Funeral director James F. ScarpelliAddress Cumberland, Md.19. Nov. 12, 1948  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 11, 1948 at 6:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19...  
and that I last saw him Dead Nov. 11, 1948

Immediate cause of death

Coronary vascular occlusion

DURATION

at onceDue to arteriosclerosis

Due to

Other conditions Diabetes & hypotension 2 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

Deputy Medical Examiner Allegany Co23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.  
M. D. ofAddress Cumberland Md. Date signed 11-11-48

MARGIN RESERVED FOR BINDING

9:45:15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

NOV 16 1948

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

93d

11022

Reg. Dist. No. 10

## 1. PLACE OF DEATH:

County AlleganyCity or town Mt. Savage  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? all his life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Mt. Savage  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

William Ewald

## 3. (b) Social Security Number

None

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Sarah Ewald7. Birth date of deceased (mo., day, yr.) October 9, 1865

6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Year 83 Month 1 Days 14 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Mt. Savage, Allegany, Md.  
(Town, county, and state)10. Usual occupation Superintendent motive power11. Industry of business C. & P. R.R. Co.12. Name John Ewald13. Birthplace Germany14. Maiden name Margaret Heuchel15. Birthplace Germany18. Informant Margaret EwaldAddress Mt. Savage, Md.17. Burial Date thereof Nov. 26, 1948  
(Burial, cremation, or removal. Which) (month) (day) (year)Cemetery or crematory St. George's CemeteryLocation Mt. Savage, Md.18. Funeral director J. R. QuirtAddress Frostburg, Md.19. Nov. 26, 48 Vernick Muller  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 23, 1948 at 11:55 p.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1948 to Nov. 23, 1948and that I last saw him alive on November 23, 1948

## Immediate cause of death

Cerebral Hemorrhage  
Left Side Hemiplegia

Due to \_\_\_\_\_

Hypertension HeartDue to DiseaseOther conditions Softening of Brain

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op. \_\_\_\_\_

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE F. A. G. MunnAddress Amherst, Md. Date signed Nov 25, 48

RECEIVED

NOV 29 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

11023

Reg. Dist. No. 9

## 1. PLACE OF DEATH:

County Allegany  
 City or town Carlos Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 hour  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Md. County Allegany  
 City or town Grahamtown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war World War 2

## 3. (a) FULL NAME

Joseph E. Fatkin

## 3. (b) Social Security Number

213-05-7157

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Nellie Plummer Fatkin

7. Birth date of deceased (mo., day, yr.) November 11, 1908

8. AGE: Years 40 Months 0 Days 15 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Shaft, Allegany, Maryland  
 (Town, county, and state)

10. Usual occupation Bus driver

11. Industry or business C. & W. Transit Co.

12. Name John Fatkin

13. Birthplace Maryland

14. Maiden name Catherine Chapman

15. Birthplace Elk Garden, W. Va.

16. Informant Mrs. David Middleton,

Address Frostburg, Md.

17. Burial Date thereof Nov. 29 '48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Allegany Cemetery,

Location Frostburg, Md.

18. Funeral director J. R. Durst,

Address Frostburg, Md.

19. 11-29 1948 Harvey N. Roe  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 26 1948 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19\_\_\_\_, to \_\_\_\_\_ 19\_\_\_\_

and that I last saw him Dead Nov. 26 1948

Immediate cause of death Acute dilatation of the heart

Due to Over-exertion

Duration at once

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H. V. Deming M.D. H. V. Deming  
 M.D. or other \_\_\_\_\_

Address Cumberland Md. Date signed 11-27-48

RECEIVED

DEC 2 1948

BUREAU V. O.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

11024

## 1. PLACE OF DEATH:

County Allegany  
 City or town Cumberland Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 5 mins.  
 Hospital, institution, or street address where death occurred  
7 Harrison Street  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany  
 City or town Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 7 Harrison St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Baby Feathers, MAUDE ARLENE

## 3. (b) Social Security Number

None

4. Sex

Female white single

5. Color or race

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 6- 19488. AGE: Years Months Days If less than one day  
5 1/2 to 6 months in utero9. Birthplace Cumberland Allegany Md.  
(Town, county, and state)10. Usual occupation None

11. Industry or business

12. Name Garland Henry Feathers13. Birthplace Terra Alta W.Va14. Maiden name LOUETTA Lula Durst15. Birthplace Cove Md.16. Informant Garland Feathers  
Address 7 Harrison St. Cumberland17. Burial Nov 8 - 48  
(Burial, cremation, or removal, Which?) Date thereof (month) (day) (year)  
Zion Memorial ParkCemetery or crematory  
Location Cumberland, Md.18. Funeral director John C. Wolford  
Address 125 S Liberty St.19. Nov. 8, 1948  
(Date rec'd by registrar) Registrar W.R. Jantz, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6, 1948, at 6:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
19... to 19...  
and that I last saw him/her alive on Nov. 6, 1948Immediate cause of death Spontaneous seperation of the placenta.  
DURATION 5 min.Due to 5 1/2 to 6 mos. in utero

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy Medical Examiner - Allegany Co.23. SIGNATURE H.V. Deming M.D.  
M. D. or otherAddress Cumberland Md. Date signed 11-7-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 16 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

11025

## 1. PLACE OF DEATH:

County AlleganyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 86 Yrs.

Hospital, institution, or street address where death occurred:

330 Beall St.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)Street No. 330 Beall St.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Mary Rossworm Feidt

## 3. (b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced	
<u>Female</u>	<u>White</u>	<u>Widowed</u>	
6.(b) Name of husband or wife <u>William H. Feidt</u>			
6.(c) If alive, give age years			
7. Birth date of deceased (mo., day, yr.) <u>Oct. 15, 1862</u>			
8. AGE:	Years	Months	Days
	<u>86</u>	<u>0</u>	<u>21</u>
	hrs. min.		

9. Birthplace Cumberland, Md.  
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name George Rossworm13. Birthplace Germany14. Maiden name Mary Ann Schlaifdt15. Birthplace Germany16. Informant Mrs. Chas. WinebrennerAddress 330 Beall St. Cumberland, Md.17. Burial Date thereof Nov. 9, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory S.S. Peter & PaulLocation Cumberland, Md.18. Funeral director Charles L. GeorgeAddress Cumberland, Md.19. Nov. 8, 1948 W.R. Fantz, M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6, 194821. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Past ten Years 1938 to Nov. 5, 1948and that I last saw her alive on November 5, 1948  
Immediate cause of death UremiaDURATION  
4 days.Due to Chronic Nephritis 10 Yrs.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury injured at work?

23. SIGNATURE J.A. Currier M. D. or otherAddress 41 Green Street, Cumberland Date signed 11/8/48

**RECEIVED**

NOV 16 1948

**BUREAU V. S.**



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 11026

### 1. PLACE OF DEATH:

County Allegany  
City or town Frostburg  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 16 years  
Hospital, institution, or street address where death occurred:  
101 Mc Culloch St.  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany  
City or town Frostburg  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 101 Mc Culloch St.  
(If rural, give LOCATION)  
2(a) If veteran, name war

### 3. (a) FULL NAME

Thomas Alexander Franklin

### 3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
6. (b) Name of husband or wife Sarah Trindle  
7. Birth date of deceased (mo., day, yr.) Aug. 29th, 1875 6. (c) If alive, give age 67 years  
8. AGE: Years 73 Months 3 Days 1 If less than one day  
hrs. min.

9. Birthplace Southern Maryland  
(Town, county, and state)

10. Usual occupation Retired Printer

11. Industry or business Bureau of Printing & Engraving

12. Name Thomas Alexander Franklin

13. Birthplace Southern Maryland

14. Maiden name Louisa Speer

15. Birthplace Southern Maryland

16. Informant Mrs. Thos. A. Franklin

Address 101 Mc Culloch St. Frostburg Md.

17. Burial Date thereof Nov 27/1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cedar Hill

Location Washington, D. C.

18. Funeral director Jacob Wapner

Address Frostburg, Md.

19. 11-25- 19 48 Mrs. Nancy V. Re  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 24 19 48 at 1:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1946 19 48 to Nov 24 19 48  
and that I last saw him alive on Nov 18 19 48

Immediate cause of death Arterio Sclerosis DURATION several years

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE WOM Lane MD

Address Frostburg Md. Date signed Nov 25 1948

MARGIN RESERVED FOR BINDING

I

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 27 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County AlleghenyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution or street address where death occurred

Allegheny Hospital  
about 3 wks

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State W. Va County MonroeCity or town Keyser  
(If outside city or town limits, write RURAL and give nearest town)Street No. 333 S Main  
(If rural, give LOCATION)2.(a) If veteran, name war no ✓

## 3. (a) FULL NAME

Robert Elias Fromhart

## 3. (b) Social Security Number

4. Sex m 5. Color or race w 6.(a) Single, married, widowed, or divorced m6.(b) Name of husband or wife Sadu Fromhart7. Birth date of deceased (mo., day, yr.) Mar 5 - 1875 6.(c) If alive, give age \_\_\_\_\_ years8. AGE: Years 72 Months 8 Days 10 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Newburg W. Va  
(Town, county, and state)10. Usual occupation Locomotive Engineer - Retired11. Industry or business B. & O. R. R. Co.12. Name Fredrick Fromhart13. Birthplace Germany14. Maiden name E. Ellen Fromhart15. Birthplace Pa. Park W. Va16. Informant E. W. FromhartAddress Keyser W. Va17. Burial Date thereof 11/18/48  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetary or crematory St ThomasLocation Keyser W. Va.18. Funeral director B. H. MarkwoodAddress Keyser W. Va19. Nov. 17, 1948 W. R. Tautz, M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 15, 1948 at 3:00 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 28, 1948 to Nov 15, 1948and that I last saw him alive on Nov 15, 1948

Immediate cause of death \_\_\_\_\_ DURATION \_\_\_\_\_

Pulmonary Embolism 10 minutes

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations Carcinoma of prostateDate of op. Nov 4-48

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, pub'c place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ injured at work?

23. SIGNATURE R. T. Trevasick, SrAddress Cumberland, Md M. D. or other \_\_\_\_\_Date signed 11/16/48

RECEIVED

NOV 23 1948

BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 112 11028

1. PLACE OF DEATH:  
County Allegheny  
City or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 30 yrs  
Hospital, institution or street address where death occurred:  
606 Arundale Ave.  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Maryland County Allegheny  
City or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 606 Arundale Ave.  
(If rural, give LOCATION)  
2.(a) If veteran, name war 1st World War

3.(a) FULL NAME George Raymond Gormer

3.(b) Social Security Number 705-12-0959

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
6.(b) Name of husband or wife Helen Hensel  
7. Birth date of deceased (mo., day, yr.) July 21 1893  
8. AGE: Years 55 Months 3 Days 25 If less than one day hrs. min.

9. Birthplace Maryland  
(Town, county, and state)  
10. Usual occupation Engineer  
11. Industry or business B & O Ry.

12. Name Henry Gormer  
13. Birthplace Ind.  
14. Maiden name Genevieve Bissel  
15. Birthplace Ind.

16. Informant Mrs. Helen H. Gormer  
Address Cumberland  
17. Burial Date thereof Nov 18 48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rox Hill Cem.  
Location Cumberland  
18. Funeral director Louis Stein) Inc  
Address Cumberland

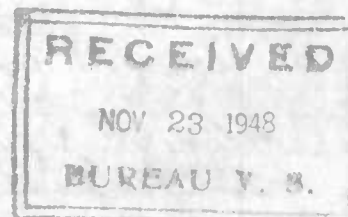
19. Nov. 17 1948 W. H. Brantz, M.D.  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION  
20. DATE OF DEATH Nov 16 1948 at 5:30 A.M.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/5/48 1948 and that I last saw him alive on 11/16/48 1948  
Immediate cause of death Myocardial Failure  
Due to Arteriosclerotic Bronchitis  
Due to  
Other conditions  
(Include pregnancy within 3 months of death)  
Major findings of operations  
Date of op.  
Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.  
22. VIOLENCE: If death was due to external causes, till in the following:  
Accident, suicide, or homicide  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work  
23. SIGNATURE [Signature] M. D. or other  
Address Cumberland Date signed 11/16/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



*Alfred Richard Williams*



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

11029

Reg. Dist. No. 10

## 1. PLACE OF DEATH:

County Allegany  
 City or town Mt Savage  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? all his life  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany  
 City or town Mt Savage  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

James J. Graham

## 3. (b) Social Security Number

214-07-0442

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Dorothy Graham

## 7. Birth date of deceased (mo., day, yr.)

November 5, 1885

## 6. (c) If alive, give age \_\_\_\_\_ years

## 8. AGE:

Years

Months

Days

If less than one day

6306

hrs.

min.

## 9. Birthplace

Mt Savage, Allegany Md.  
(Town, county, and state)

## 10. Usual occupation

Carpenter, Joiner

## 11. Industry or business

Kelly Springfield Co.

## 12. Name

James Graham

## 13. Birthplace

Mt Savage Md.

## 14. Maiden name

Elizabeth Morgan

## 15. Birthplace

England

## 16. Informant

George Graham

## Address

Mt Savage Md.

## 17. Burial

(Burial, cremation, or removal) Which

Date thereof Nov 15, 1948  
(month) (day) (year)

## Cemetery or crematory

Mt George Cemetery

## Location

Mt Savage Md.

## 18. Funeral director

J. R. O'Neil

## Address

Fitchburg Md.

## 19. Nov 13

19 48  
(Date rec'd by registrar)Vernice Kuller  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 11-12-1948 at 2:40 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Jan 1940 to 11-12-1948and that I last saw him alive on 11-12-1948Immediate cause of death Chronic Hypertensive DURATION 4 yrs  
Cardio-renal disease

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE

John A. Lopez

M. D. or other

Address Hyndman Date signed 11-12-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 16 1948

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

William Corporate Limits

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

93d

11030

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County Allegheny  
 City or town Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 45 yrs.  
 Hospital, institution, or street address where death occurred:  
Allegheny Co. Infirmary  
 How long in hospital or institution? 2 yrs

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Allegheny  
 City or town Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 645 Shriver Ave.  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Mrs Catherine Graves

## 3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Divorced

6. (b) Name of husband or wife

John Graves

6. (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) April 4 1871

8. AGE: Years 77 Months 7 Days 6 It less than one day hrs. min.

9. Birthplace Oakland, Allegheny Co., Md.  
(Town, county, and state)10. Usual occupation Housework

## 11. Industry or business

12. Name Christian Yutz13. Birthplace Unknown14. Maiden name Dinah Schlach15. Birthplace Unknown16. Informant Mrs. John C. RussellAddress 645 Shriver Ave., Cumberland, Md.17. Burial Date thereof November 12, 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Hillcrest Burial ParkLocation Cumberland, Md.18. Funeral director Wm. J. HoyerAddress Cumberland, Md.19. Nov 12 48 Wm. J. Hoyer M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 10 19 48 at 5:00 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 19 46 to Nov. 10 19 48and that I last saw him alive on Nov. 9 19 48Immediate cause of death Chronic Heart FailureDue to Chr. HypertensionDue to Senility

Other conditions

(Include pregnancy within 3 months of death)

Major findings at operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

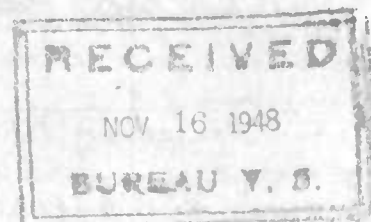
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Arthur F. Jones, Jr., M.D.Address 110 S. Centre St. Date signed 11-10-48

DURATION

1 Wks.3 mos.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

11031

1. PLACE OF DEATH:

County Allegheny  
City or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 2 years  
Hospital, institution, or street address where death occurred:  
422 Columbia St.  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Md County Allegheny  
City or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 422 Columbia St  
(If rural, give LOCATION)  
2(a) If veteran, name World War I

3. (a) FULL NAME

James Norman Gunnette

3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Odessa Miller

7. Birth date of deceased (mo., day, yr.) October 1, 1893 6. (c) If alive, give age years

8. AGE: Years 55 Months 1 Days 15 If less than one day hrs. min.

9. Birthplace Frostburg, Allegheny, Md.  
(Town, county, and state)

10. Usual occupation Contractor

11. Industry or business Plasterer

12. Name Theodore Gunnette

13. Birthplace Madison, Pa.

14. Maiden name Sarah Weems Franklin

15. Birthplace Ann Arundel Co., Md.

16. Informant Mrs. Sarah Gunnette

Address 422 Columbia St., Cumberland, Md

17. Burial Date thereof November 18, 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Allegheny Cemetery

Location Frostburg, Md.

18. Funeral director John J. Neff

Address Cumberland, Md.

19. Nov. 18, 1948 W. J. Hantz, Md.  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 16, 1948 at 4:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 3, 1947 to November 16, 1948

and that I last saw him alive on November 16, 1948

Immediate cause of death Heart failure

Due to arteriosclerosis and

hypertensive heart disease

Due to pulmonary heart disease

pulmonary fibrosis

Other conditions obesity

(Include pregnancy within 3 months of death)

Major findings of operations no

Date of op. no

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, pub'c place (where?)

Means of injury Injured at work?

23. SIGNATURE Avella G. Weissman M. D. or other

Address 122 Bedford St., Cumberland Date signed 11/18/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 23 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

11033

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County... Allegheny  
 City or town... Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 24 yrs  
 Hospital, institution, or street address where death occurred:  
Allegheny Hospital  
 How long in hospital or institution? 2 1/2 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State... Ind County... Allegheny  
 City or town... Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 12 N. Lee St.  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Mrs Catherine Mary Healy

## 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife Mark P. Healy

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 10, 1883

8. AGE: Years 64 Months 11 Days 28 If less than one day  
 hrs. min.

9. Birthplace Frostburg, Allegheny Co, Ind  
(Town, county, and state)10. Usual occupation Housewife11. Industry or business at home12. Name Darby Brady13. Birthplace Frostburg, Ind.14. Maiden name Marcella Skeltis15. Birthplace Frostburg, Ind.16. Informant Darby HealyAddress 221 Green St Cumb Md.17. Burial Date thereof Nov 11, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St Michael's CemeteryLocation Frostburg Md.18. Funeral director John J. HalpinAddress Cumberland Ind.19. Nov. 10, 1948 W.R. Fank, M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 8 1948 at 4:55 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from SPE 1948 to Nov 8 1948and that I last saw him alive on Nov 7 1948Immediate cause of death Diabetic ComaDue to DiabetesDue to Chronic NephritisDue to Hypertension Heart andOther conditions Diabetes

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE P. Allen G. Munro, M.D.Address Cumberland Ind. Date signed Nov 10

DURATION

4 daysNov 111948year1948year1948year1948year1948year1948

MARGIN RESERVED FOR BINDING

9-43-15M

VS A16

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 16 1948

BUREAU V. S.

*harrill*



Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11032

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany  
City or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
Allegany Hospital  
How long in hospital or institution? 2 Wks.

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Allegany  
City or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 404 Seymore St.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

3. (a) FULL NAME

Lawrence J. Hilton

3. (b) Social Security Number

705-09-9814

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Blanche (Chaney)

7. Birth date of deceased (mo., day, yr.) April 15, 1902 6.(c) If alive, give age years

8. AGE: Years 46 Months 6 Days 18 It less than one day hrs. min.

9. Birthplace Reading Pa.  
(Town, county, and state)

10. Usual occupation Boilermaker

11. Industry or business B & O R.R.

12. Name Lawrence

13. Birthplace Germany

14. Maiden name Anna Kuhmann

15. Birthplace Germany

16. Informant Wife

Address 404 Seymore St.

17. No Burial Date thereof November 6, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Mary's Cem.

Location Cumberland, Md.

18. Funeral director James E. Scarpelli

Address Cumberland, Md.

19. Nov 4 1948 W. F. Tantz, M.D.  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 3 1948 at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/18/48 to Nov 3 1948  
and that I last saw him alive on 11/3/48 1948

Immediate cause of death Unnatural death

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Unnatural death

No Reason Date of op. 10/24/48

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John R. Rozum M. D. or other

Address Cumberland Date signed 11/3/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11034

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County AlleganyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County AlleganyCity or town Cumberland, Md  
(If outside city or town limits, write RURAL and give nearest town)Street No. 20 Ridgeway Terrace  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Jean Jarvis Haller

## 3. (b) Social Security Number

None

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

FemaleWhiteSingle

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

Dec 22, 1928

8. AGE:

Years

Months

Days

If less than one day

191018

hrs.

min.

9. Birthplace

Cumberland Allegany Co Md  
(Town, county, and state)

10. Usual occupation

none

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19. 48

W.R. Frantz, M.D.

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov 1019. 48 at 3:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct19. 46

to

Nov. 1019. 48

and that I last saw her alive on

Nov. 1019. 48

Immediate cause of death

Cerebral edema

DURATION

8 hrs.

Due to

Congenital Cerebral Spastic1948

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Arthur J. Jones M.D.

M. D. or other

Address

1105 Centre StDate signed 11-12-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 16 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11035

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County AlleganyCity or town Cumberland Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Windsor Hotel, Baltimore St.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltimoreCity or town Towson  
(If outside city or town limits, write RURAL and give nearest town)Street No. 64 Burkleigh Road.

(If rural, give LOCATION)

2. (a) If veteran, name war Spanish Am.

## 3. (a) FULL NAME

Nelson Alexander Hopkins

## 3. (b) Social Security Number

213-01-4330 A4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced widower6. (b) Name of husband or wife Mary Elizabeth Sullivan Hopkins7. Birth date of deceased (mo., day, yr.) May 4- 18748. AGE: Years 74 Months 6 Days 3 It less than one day hrs. min.9. Birthplace Louisville Ky.  
(Town, county, and state)10. Usual occupation retired

11. Industry or business

12. Name Wallace Hopkins13. Birthplace unknown14. Maiden name Tabitha Winters15. Birthplace unknown16. Informant Mrs. Rella Harvey (daughter)Address 64 Burkleigh Rd. Towson Md.17. Removal of Burial Date thereof Nov 9 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory FAIRVIEW CEMETERYLocation New Albany, Ind.18. Funeral direct CHARLES L. GEORGEAddress CUMBERLAND, MARYLAND19. Nov 8 19 48 W.R. Franky, Md.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 7 1948 at 8.30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him Dead Nov. 7 1948Immediate cause of death Chronic MyocarditisDURATION 2 yrs.Other conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy Medical Examiner - Allegany Co.Signature H.V. Deming M.D. H.V. Deming M.D.Address Cumberland Md. Date signed 11-7-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 16 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

11036

Reg. Dist. No. 10

## 1. PLACE OF DEATH:

County..... Allegheny  
 City or town..... Buttsburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 1 1/2 yrs  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... Maryland County..... Allegheny  
 City or town..... Buttsburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Joseph Michael Hoyer

## 3. (b) Social Security Number

182-01-4255-A

4. Sex..... 5. Color or race..... 6. (a) Single, married, widowed, or divorced.....

Male White Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)..... 6. (c) If alive, give age..... years

April 12, 1879  
 8. AGE: Years..... Months..... Days..... If less than one day.....  
69 6 23 ..hrs. ....min.

9. Birthplace.....

Frostburg, Allegheny, Md.  
 (Town, county, and state)

10. Usual occupation.....

retired miner

11. Industry or business.....

12. Name.....

Patrick Hoyer

13. Birthplace.....

Pa

14. Maiden name.....

Elizabeth Conroy

15. Birthplace.....

unknown

16. Informant.....

Vernard Wimmer

Address.....

Lonaconing, Md.

17. (Burial, cremation, or removal, Which?)..... Date thereon..... (month) (day) (year)

Buried 11/5/48

Cemetery or crematory.....

St. Michaels

Location.....

Frostburg, Md.

18. Funeral director.....

Jacob Hafer

Address.....

Frostburg, Maryland

19. (Date rec'd by registrar)..... Registrar.....

Nov. 7 - 1948 Vernard Wimmer

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... 5 November 1948, at..... M

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

30 October 48 to 5 November 48

and that I last saw him alive on 4 November 48

Immediate cause of death..... DURATION

Cerebral Hemorrhage

hypertension & arteriosclerosis

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results..... Date of op.....

None done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....

John B. Davis M.D.

Address..... Date signed.....

Frostburg, Md. 11/6/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 9 1948

BUREAU V. S.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11064

## CERTIFICATE OF DEATH

Reg. Dist. No.

4

## 1. PLACE OF DEATH:

County... AlleghenyCity or town... Cumberland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

633 Hill Top Drive

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Ind County... AlleghenyCity or town... Cumberland  
(If outside city or town limits, write RURAL and give nearest town)Street No. 633 Hill Top Drive  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

Mrs Amanda Hazel James

## 3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife... Theodore S. James

6. (c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.) May 29, 1892

8. AGE: Years Months Days If less than one day

56 5 15 hrs. min.9. Birthplace... East Allegheny Co. Ind.  
(Town, county, and state)10. Usual occupation... Housework11. Industry or business... at Home12. Name... Conner Gross13. Birthplace... Allegheny Co. Ind.14. Maiden name... Victoria Bowman15. Birthplace... Artemus Pa.16. Informant... Walter CrabtreeAddress... 633 Hill Top Drive Cumb Ind17. Burial Date thereof... Nov 16, 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory... Greenmount CemeteryLocation... Cumberland Ind.18. Funeral director... John J. HaferAddress... Cumberland Ind.19. Nov 16 19 48 W.R. Hantz, M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... Nov 14 19 48, at 11:15 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 4 19 48 to Nov 14 19 48and that I last saw her alive on November 14 19 48Immediate cause of death... Coronary vascular accidentDue to... Hypertension

Due to...

Other conditions...

(Include pregnancy within 8 months of death)

Major findings of operations...

Date of op...

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... Geo. M. Brown M. D. or otherAddress... 128 Union St. Date signed 11/14/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 23 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

11037

Reg. Dist. No. 9

### 1. PLACE OF DEATH:

County... Allegany  
City or town... Frostburg Md.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 15 minutes  
Hospital, institution, or street address where death occurred:  
Miners Hospital, Frostburg Md.  
How long in hospital or institution? 15 minutes

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md. County... Allegany  
City or town... Frostburg  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 156 Green St. Extended  
(If rural, give LOCATION)  
2.(a) If veteran, name war... World War 2

### 3. (a) FULL NAME

William Edwin Jeffries

### 3. (b) Social Security Number

217-18-4740

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married  
6.(b) Name of husband or wife... Margaret Buskirk  
6.(c) If alive, give age... 24 years  
7. Birth date of deceased (mo., day, yr.) Feb. 18-1924  
8. AGE: Years 24 Months 9 Days 7 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

### MEDICAL CERTIFICATION

20. DATE OF DEATH... Nov. 25 19 48 at 5 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_  
and that I last saw him Dead Nov. 25 19 48

Immediate cause of death... Intracranial hemorrhage DURATION 45 minutes

Due to a fracture of the skull, also had a fracture of the 6th cervical vertebrae, due to an automobile accident.  
Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations... \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results... \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide auto. accident Date of Nov. 25/48  
Where did injury occur? near Morantown Allegany Md.  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Route 36  
Means of injury Lost control of motor no  
Deputy Medical Examiner - Allegany Co

23. SIGNATURE H.V. Deming M.D. H.V. Deming Md M. D. Examiner  
Address Cumberland Md. Date signed 11-25-48

9. Birthplace... Midland Md.  
(Town, county, and state)  
10. Usual occupation... Plumber  
11. Industry or business... Own Shop  
12. Name... Alfred Jeffries  
13. Birthplace... Frostburg Md.  
14. Maiden name... Beulah Wilson  
15. Birthplace... Frostburg Md.  
16. Informant... Mrs William E. Jeffries  
Address... Frostburg, Md.  
17. Burial Date thereof... Nov 28, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory... Allegany Cemetery  
Location... Frostburg, Md.  
18. Funeral director... M. Eickhorn  
Address... Lonaconing, Md.  
19. 11-27 19 48 Mc Henry N. Roe  
(Date rec'd by registrar) Registrar

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

RECEIVED

NOV 30 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 9

11038 Davis

93d

## 1. PLACE OF DEATH:

County Allegany  
City or town Smithsburg  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

115 Front Ave.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County alleganyCity or town Smithsburg  
(If outside city or town limits, write RURAL and give nearest town)Street No. 6 Broadway  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Amy May Kallbaugh

## 3. (b) Social Security Number

none

4. Sex

Female

5. Color or race

white

6.(a) Single, married, widowed, or divorced

widowed

6.(b) Name of husband or wife

D. Webster Kallbaugh

7. Birth date of deceased (mo., day, yr.)

May 21 - 1864

6.(c) If alive, give age

years

8. AGE:

Years 84 Months 5 Days 10 If less than one day

9. Birthplace

mt. Savage - alleg - md  
(Town, county, and state)

10. Usual occupation

housewife

11. Industry or business

12. Name David Thomas

13. Birthplace

unknown

14. Maiden name

Harriet Lewis

15. Birthplace

Wales

16. Informant

Adam Kallbaugh

17. (Burial, cremation, or removal. Which?)

Burial Date thereof Nov. 4 - 1948  
(month) (day) (year)

Cemetery or crematory

allegany

Location

Smithsburg, md.

18. Funeral director

J.R. Duff19. 11-4  
(Date rec'd by registrar)Ms. Nancy A. Roe  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 1, 1948 at 11:00 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

30 October 1948 to 1 Nov 1948and that I last saw her alive on 1 November 1948Immediate cause of death acute congestiveheart failure. DURATIONDue to chronic myocardialheart disease.

Due to

Other conditions chronic cholelithiasis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results none done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

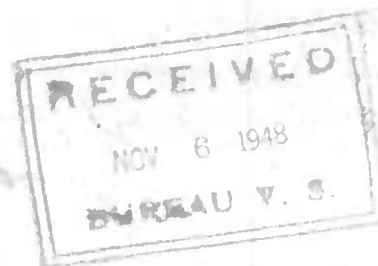
Signature John B. Davis, M.D.Address Smithsburg, md Date signed 11/2/48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 11039 4

## 1. PLACE OF DEATH:

County AlleganyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Lonaconing  
(If outside city or town limits, write RURAL and give nearest town)Street No. Man St

(If rural, give LOCATION)

2(a) If veteran, name war

## 3. (a) FULL NAME

MARY Baby Kelly

## 3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

child

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Nov. 8, 19488. (c) If alive, give age 2 years

8. AGE:

Years

Months

Days

It less than one day

hrs. 5 min.9. Birthplace Cumberland, Allegany, Md.  
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name William Kelly13. Birthplace Lonaconing, Md.14. Maiden name Antonette Urbas15. Birthplace Valle Summit, Md.16. Informant Mrs William KellyAddress Lonaconing, Md.17. Burial Date thereof Nov. 8, 1948

(Burial, cremation, or removal. Which?)

Cemetery or crematory St. Michael CemeteryLocation Portbury, Md.18. Funeral director M. EickhornAddress Lonaconing, Md.19. Nov. 8, 1948 W. H. Frank, M.D.

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 11-7- 19 48, at 5:30 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-7- 19 48, to 11-7- 19 48and that I last saw him alive on 11-7-48 19 48

Immediate cause of death

premature baby  
5 1/2 mo

DURATION

5 hours

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE L. King M.D. M. D. or otherAddress 59 Green St. Date signed 11-8-48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C.

RECEIVED  
NOV 18 1948  
BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11040

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County Allegany  
City or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

721 Lafayette Ave.,

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)Street No. 721 Lafayette Ave.,  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

VIRGINIA BELLE KESSEL

## 3. (b) Social Security Number

None

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife J. Staten Kessel

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Sept. 25, 1866

## 8. AGE:

Years

Months

Days

It less than one day

82123

hrs. min.

9. Birthplace Deer Park, Maryland  
(Town, county, and state)10. Usual occupation Housewife

## 11. Industry or business

FATHER  
MOTHER12. Name Jackson Bobo13. Birthplace W. Va.14. Maiden name Amanda Michael15. Birthplace W. Va.16. Informant Mrs. Roy E. VanFleetAddress 721 Lafayette Ave., Cumberland, Md17. Burial Date thereof Nov. 21, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory United Brethren Cem.Location Laymansville, W. Va.19. Funeral director Charles L. GeorgeAddress Cumberland, Md.19. Nov. 19, 1948 W. R. Tantz, M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 18, 1948 at 2:40 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 15, 1948 to Nov. 18, 1948  
and that I last saw him alive on Nov. 17, 1948

Immediate cause of death

Arteriosclerosis

DURATION

6 mos.Due to ArteriosclerosisDue to Myocarditis5 yr

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Clayton L. Jones M. D. or otherAddress Cumberland Date signed 11/19/48

RECEIVED

NOV 23 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

County Allegany  
 City or town Westernport  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 67 years  
 Hospital, institution, or street address where death occurred:  
211 Vine Street  
 How long in hospital or institution? - - - - -

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany  
 City or town Westernport  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 211 Vine Street  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war - - - - -

## 3. (a) FULL NAME

ELIZA ANN KIGHT

## 3. (b) Social Security Number

- - -

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow  
 6. (b) Name of husband or wife Charles A. Kight  
 6. (c) If alive, give age - - years  
 7. Birth date of deceased (mo., day, yr.) March 17, 1861  
 8. AGE: Years 87 Months 8 Days 9 If less than one day - - - hrs. - - min.

9. Birthplace Barton, Allegany, Maryland  
 (Town, county, and state)  
 10. Usual occupation Housewife  
 11. Industry or business own home  
 12. Name Thomas Gilbert  
 13. Birthplace England  
 14. Maiden name Eliza Wilson  
 15. Birthplace England

16. Informant Mrs Robert Montgomery  
 Address Westernport, Maryland  
 17. Burial Burial Date thereof Nov 28, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Philos Cemetery  
 Location Westernport, Maryland  
 18. Funeral director Ellsworth S. Boal  
 Address Westernport, Maryland

19. Nov 28 19 48 Allegany  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 26, 19 48, at 1:30am

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 2, 19 48, to Nov 26, 19 48, and that I last saw her alive on November 25, 19 48.

Immediate cause of death Pulmonary Edema DURATION 2 Days

Due to Chronic Myocarditis and Myocardial Degeneration Not Specified As Rheumatic. 3 Years

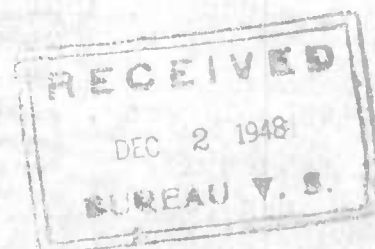
Other conditions - - - - -  
 (Include pregnancy within 3 months of death)

Major findings of operations None Date of op. - - - - -

Autopsy results None  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None  
 Accident, suicide, or homicide - - - - - Date of - - - - -  
 Where did injury occur? - - - - - (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) - - - - -  
 Means of injury - - - - - Injured at work? - - - - -

23. SIGNATURE Paul R Wilson, M.D. M. D. or other - - - - -  
Piedmont, W. Va. Address - - - - - Date signed 11-27-48



8

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11042

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County ALLEGANY  
 City or town CUMBERLAND  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 40 YEARS  
 Hospital, institution, or street address where death occurred:  
MEMORIAL HOSPITAL  
 How long in hospital or institution? 10 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY  
 City or town CUMBERLAND  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1011 GLENWOOD STREET  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

MRS. IRENE G. KING

## 3. (b) Social Security Number

None

## 4. Sex

FEMALE

## 5. Color or race

WHITE

## 6. (a) Single, married, widowed, or divorced

MARRIED

## 6. (b) Name of husband or wife

WILBUR O. KING

## 6. (c) If alive, give age

43

## 7. Birth date of deceased (mo., day, yr.)

JUNE 7, 1907

## 8. AGE:

Years

Months

Days

If less than one day

41

5

5

.....hrs. s.....min.

## 9. Birthplace

MARYLAND

(Town, county, and state)

## 10. Usual occupation

HOUSE WIFE

## 11. Industry or business

FATHER  
MOTHER

## 12. Name

ROWE, ARTHUR

## 13. Birthplace

HAGERSTOWN Md.

## 14. Maiden name

HALLIER, CHARLOTTE

## 15. Birthplace

MAUCH CHUNK, PA.

## 16. Informant

MEMORIAL HOSPITAL

## Address

MEMORIAL AVE., CITY

## 17.

Burial  
(Burial, cremation, or removal. Which?)Date thereof NOV. 16 48  
(month) (day) (year)

## Cemetery or crematory

ROSE HILL CEM.

## Location

Cumberland Md.

## 18. Funeral director

Louis Stein Inc

## Address

Cumberland Md.

## 19.

Nov 16 19 48  
(Date rec'd by registrar)W. F. Dancy M.D.  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH NOVEMBER 12, 1948 at 11:30 P21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/30/48 to 11/12/48and that I last saw him alive on 11/12/48

Immediate cause of death

Metastatic Carcinoma Unknown

Due to

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Metastatic adenocarcinoma of prostateDate of op. 11/15/48

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Address

Date signed

**RECEIVED**

NOV 23 1948

**BUREAU V. S.**



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

11043

Reg. Dist. No. 932 05

## 1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No. ....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Married

6. (b) Name of husband or wife

6. (c) If alive, give age

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

43

9

24

hrs.

min.

9. Birthplace

Midland Allegany Co. Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal, Which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

RECEIVED

JAN 7 1949

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 9

## 1. PLACE OF DEATH:

County AlleganyCity or town Smithsburg  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

15 Welsh St.,

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County alleganyCity or town Smithsburg  
(If outside city or town limits, write RURAL and give nearest town)Street No. 15 Welsh  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

Anna Louise Layman

## 3. (b) Social Security Number

none

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Geo Layman

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

July 7-1854

8. AGE:

Years

Months

Days

If less than one day

94421

hrs.

min.

9. Birthplace

Garnett - md.  
(Town, county, and state)

10. Usual occupation

house wife

11. Industry or business

MOTHER FATHER

12. Name

Nelson Crowe

13. Birthplace

Smith Co., md.

14. Maiden name

Mary Ann Winebrenner

15. Birthplace

md.

16. Informant

George Layman

Address

P.O. Smithsburg, md.

17. Burial (Burial, cremation, or removal, Which?)

Date thereof

Dec 1-1948  
(month) (day) (year)

Cemetery or crematory

allegany

Location

Smithsburg, md.

18. Funeral director

J.R. Priest

Address

Smithsburg, md.19. 12-1  
(Date rec'd by registrar)48 Mrs. Nancy & Roe  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 28 November 1948 at 4:55 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

11 Nov 1948 to 28 Nov 1948and that I last saw her alive on 28 Nov 1948

Immediate cause of death

Arteriosclerosis  
Thrombosis

DURATION

Due to

arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations none done

Autopsy results

none done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John B. Davis, md.

M. D. or other

Address Smithsburg, md. Date signed 11/29/48

RECEIVED

DEC 2 1948

BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Rec'd

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No. 4

## 1. PLACE OF DEATH:

County AlleganyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 24 years

Hospital, institution, or street address where death occurred:

311 Franklin St.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County AlleganyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)Street No. 311 Franklin St.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Charles William Light

## 3. (b) Social Security Number

None

4. Sex

M

5. Color or race

W

8. (a) Single, married, widowed, or divorced

Single

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 29 1945 at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to ..... 19.....

and that I last saw him alive on ..... 19.....

Immediate cause of death

Myocardial InfarctionDue to Myocardial InfarctionDue to Myocardial Infarction

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) August 26, 1878

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

7033

hrs.

min.

9. Birthplace Orleans Cross Roads, Morgan Co. W.Va.  
(Town, county, and state)10. Usual occupation Carpenter, retired11. Industry or business Construction work12. Name Henry F. Light13. Birthplace Martinsburg, W.Va.14. Maiden name Catherine Sweitzer15. Birthplace Pearre, Md.16. Informant Mrs. Rosa E. LewisAddress 311 Franklin St., Cumberland, Md.17. Burial Date thereof December 2, 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Hillcrest Burial ParkLocation Cumberland, Md.18. Funeral director John J. WolfeAddress Cumberland, Md.19. Dec. 2 1948 W.R. Raub, Md.  
(Date rec'd by registrar) Registrar23. SIGNATURE W.R. Raub M. D. or otherDate signed Dec. 2, 1948

RECEIVED  
DEC 6 1948  
BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

11046

## 1. PLACE OF DEATH:

County Allegheny  
City or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegheny Hospital  
How long in hospital or institution? 5 days

## 3. (a) FULL NAME

Mrs Hazel Gertrude Lindsay

## 3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Thomas C. Lindsay6. (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.)

Aug 24, 1901

8. AGE:

Years

47

Months

2

Days

26

If less than one day

hrs.

min.

9. Birthplace

Cass, Pocahontas Co., W. Va.  
(Town, county, and state)

10. Usual occupation

Housework

11. Industry or business

at home

FATHER

12. Name

Monroe Phillips

13. Birthplace

Parsons, W. Va.

MOTHER

14. Maiden name

Annie Cassell

15. Birthplace

Pocahontas Co., W. Va.

16. Informant

Thos. C. Lindsay

Address

141 Main St, Ridgeley, W. Va.

17. Burial

Burial  
(Burial, cremation, or removal. Which?)Date thereof Nov 22, 1948  
(month) (day) (year)

Cemetery or crematory

Zion Memorial Cem

Location

Cumberland, Md.

18. Funeral director

John J. Hager

Address

Cumberland, Md.19. Nov. 22

(Date rec'd by registrar)

19. 4819. 48W. F. Kemp, M.D.  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State W. Va County MineralCity or town Ridgeley W. Va  
(If outside city or town limits, write RURAL and give nearest town)Street No. 141 Main St  
(If rural, give LOCATION)2. (a) If veteran, name war ✓

## MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 20 19 48, at 3:30 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7 October 19 48 to Nov 20 19 48and that I last saw her alive on Nov 20 19 48Immediate cause of death Pulmonary Infarct DURATION 1 hr.congestive Heart Failure 2 daysDue to malignant Hypertension 1 monthDue to Obesity lifeOther conditions Cerebral Angiospasm - residual 1 1/2 yrs

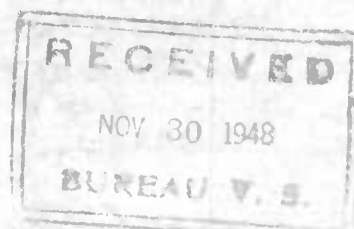
(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: NoAccident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)Injured at home, farm, industry, public place (where?) \_\_\_\_\_Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_23. SIGNATURE Harville C. Weismann M. D. or other \_\_\_\_\_Address 122 Bedford St, Cumberland Date signed 11/22/48





DR. SHINDLER

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

11047

93d

## 1. PLACE OF DEATH:

County ALLEGANY  
 City or town CUMBERLAND  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 7 DAYS  
 Hospital, institution, or street address where death occurred:  
MEMORIAL HOSPITAL  
 How long in hospital or institution? 7 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY  
 City or town Bedford Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Rt 3, Bedford Road  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

REV. ERNEST E. MANLEY

## 3. (b) Social Security Number

None

4. Sex MALE 5. Color or race WHITE 6.(a) Single, married, widowed, or divorced WIDOWED  
 6.(b) Name of husband or wife ELLA McELROY  
 6.(c) If alive, give age years  
 7. Birth date of deceased (mo., day, yr.) 7-3-1858  
 8. AGE: Years 90 Months 4 Days 3 If less than one day  
 .....hrs. ....min.

9. Birthplace WARREN CO. Canton, Penna.  
 (Town, county, and state)  
 10. Usual occupation Minister - Retired  
 11. Industry or business Preaching  
 12. Name Rev. Dewitt C. Manley  
 13. Birthplace Canton, Pa.  
 14. Maiden name Louisa Pratt  
 15. Birthplace Canton, Pa.

16. Informant MEMORIAL HOSPITAL  
 Address CUMBERLAND, MARYLAND  
 17. Burial Date thereof 11/9/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Granville Center Cemetery  
 Location Granville Center, Pa.  
 18. Funeral director William H. Kight  
 Address Cumberland, Md.

19. Nov. 8, 1948 W. H. Kight, M.D.  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH NOVEMBER 6, 1948 at 6:50 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Nov. 6, 1947 to Nov. 6, 1948  
 and that I last saw him alive on November 6, 1948  
 Immediate cause of death Broncho-Pneumonia DURATION 2 weeks  
Heart failure Chronic  
Arterio Sclerosis

Due to Broncho-Pneumonia  
 Due to Heart failure  
 Other conditions Arterio Sclerosis

(Include pregnancy within 3 months of death)  
 Major findings of operations  
 Date of op.  
 Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of Injury Injured at work?

23. SIGNATURE B. M. Shindler, M.D.  
 Address 41 Leeward Date signed Nov. 7, 1948  
 M. D. or other

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 16 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

11048

Reg. Dist. No. 8

## 1. PLACE OF DEATH:

County... Allegany  
 City or town... Lonaconing, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 50-7-2  
 Hospital, institution, or street address where death occurred: Gills Hill  
 How long in hospital or institution? 2

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... Maryland County... Allegany  
 City or town... Lonaconing  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No... Gills Hill  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war... No

## 3. (a) FULL NAME

James Matthews

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Winona Snyder  
 7. Birth date of deceased (mo., day, yr.) Apr. 17, 1898 6.(c) If alive, give age 47 years  
 8. AGE: Years 51 Months 7 Days 2 If less than one day  
 hrs. min.

9. Birthplace Lonaconing, Allegany Co., Md.  
 (Town, county, and state)

10. Usual occupation Miner

11. Industry or business Consolidation Coal Co.

12. Name Peter H. Matthews

13. Birthplace Unknown

14. Maiden name Violet Bothwell

15. Birthplace Unknown

16. Informant Mrs. Winona S. Matthews

Address Lonaconing, Md.

17. Burial Date thereof Oct. 21, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Laurel Hill Cemetery

Location Moscow, Md.

18. Funeral director M. Eichhorn

Address Lonaconing, Md.

19. Nov 21 19 48 Jannette M. Coal  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... 11 / 19 19 48, at P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 19 47, to 11 / 19 19 48  
 and that I last saw him alive on 11 / 18 19 48

Immediate cause of death Cancer of lung =  
generalized Metastases DURATION 2 yrs

Due to...  
 Due to...  
 Other conditions...  
 (Include pregnancy within 3 months of death)

Major findings of operations... Date of op. ...

Autopsy results...  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

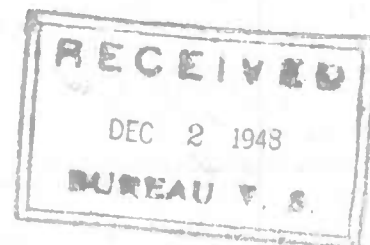
22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, pub'c place (where?)

Means of injury Injured at work?

23. SIGNATURE Paul Eugene Dye, M.D.  
Lonaconing, Md. Date signed 11/20/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

11049

1. PLACE OF DEATH:

County **ALLEGANY**

City or town **CUMBERLAND**  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? **11 DAYS**

Hospital, institution, or street address where death occurred:  
**MEMORIAL HOSPITAL**

How long in hospital or institution? **11 DAYS**

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State **MARYLAND** County **ALLEGANY**

City or town **CUMBERLAND**  
(If outside city or town limits, write RURAL and give nearest town)

Street No. **919 HARDING AVENUE**  
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

**LAWRENCE E. MEISTER**

3. (b) Social Security Number

*None*

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

**MALE WHITE MARRIED**

6. (b) Name of husband or wife **ELSIE ZEMBOWER**

6. (c) If alive, give age **67** years

7. Birth date of deceased (mo., day, yr.) **MARCH 3, 1881**

8. AGE: Years Months Days If less than one day  
**67 8 6** hrs. min.

9. Birthplace **MARYLAND**  
(Town, county, and state)

10. Usual occupation **RETIRED POLICEMAN**

11. Industry or business

12. Name **GEORGE MEISTER**

13. Birthplace *Mary land.*

14. Maiden name *Elizabeth Gore*

15. Birthplace *Mary land.*

16. Informant **MEMORIAL HOSPITAL**

Address **MEMORIAL AVE., CUMBERLAND, MD.**

17. *Burial* Date thereof **11/12/48**  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory *Trinity Lutheran*

Location *Cumberland Md.*

18. Funeral director *Louis Steier Inc.*

Address *Cumberland Md.*

19. *Nov. 12* 18 *48* *W. R. Marty, M.D.*  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **NOVEMBER 9** 19 **48** at **10:00 PM**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **30 Oct., 1948** to **9 Nov., 1948**

and that I last saw him alive on **9 November, 1948**

Immediate cause of death

**Diabetes mellitus**  
**Acute coronary occlusion**

DURATION

**Since 1936**

Due to **Arteriosclerosis, generalized.**

Due to **Peripheral vascular disease,**  
**both lower extremities with gangrene**

Other conditions **in the right foot, secondary**  
**to diabetes.**

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results **No autopsy.**

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *W. Alfred Van Ormer*  
M. D. or other

Address **Cumberland, Md.** Date signed **11-10-48**

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 16 1948

BUREAU V. S.



## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County ALLEGANY  
 City or town CUMBERLAND, MD.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 16 DAYS  
 Hospital, institution, or street address where death occurred:  
MEMORIAL HOSPITAL  
 How long in hospital or institution? 16 DAYS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State MARYLAND County Garrett  
 City or town ACCIDENT  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

MRS. NANCY MILLER

## 3. (b) Social Security Number

None

4. Sex FEMALE 5. Color or race WHITE 6.(a) Single, married, widowed, or divorced MARRIED

6.(b) Name of husband or wife SILAS MILLER6.(c) If alive, give age 74 years7. Birth date of deceased (mo., day, yr.) DECEMBER 23 1872

8. AGE: Years 75 Months 10 Days 18 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace MARYLAND  
(Town, county, and state)10. Usual occupation HOUSE WIFE

11. Industry or business

12. Name DANIEL BAKER13. Birthplace MARYLAND14. Maiden name LYDIA CAMP15. Birthplace MARYLAND16. Informant MEMORIAL HOSPITALAddress MEMORIAL AVE.,17. Removal & Burial Date thereof 11 14 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Bea CreekLocation Accident, Ind.18. Funeral director Alfred A. WhiteheadAddress Grandville, Ind.19. Nov. 11 1948 Rob. Frank, M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH NOVEMBER 11, 1948 at 5:30 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 26 1948 to Nov 11 1948and that I last saw her alive on November 10 1948Immediate cause of death Cerebrovascular Accident

(Immediate cause)

Due to Myocardial Diseasedecompensation - CardiacDue to Myocardial Disease - AnginalFibrillationOther conditions Abdominal Aortic

(Include pregnancy within 3 months of death)

Major findings at operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Samuel Jacobson M. D. or other \_\_\_\_\_Address 50 Pershing Dr Date signed 11/11/48

RECEIVED

NOV 16 1948

BUREAU V. S.

Within corporate limits

GROVE

DR. WILSON

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

127a

11051

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County ALLEGANY  
 City or town CUMBERLAND  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 8 DAYS  
 Hospital, institution, or street address where death occurred:  
MEMORIAL HOSPITAL  
8 DAYS  
 How long in hospital or institution? 8 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State WEST VIRGINIA County GRANT  
 City or town GORMANTIA  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

MRS. FANNIE E. MORELAND

## 3. (b) Social Security Number

None

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced MARRIED

6. (b) Name of husband or wife JOHN C. MORELAND

7. Birth date of deceased (mo., day, yr.) AUG. 2, 1884  
 6. (c) If alive, give age 65 years

8. AGE: Years 64 Months 3 Days 14 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace WEST VIRGINIA  
(Town, county, and state)10. Usual occupation HOUSE WIFE

## 11. Industry or business

12. Name JOHN HELMICK13. Birthplace WEST VIRGINIA14. Maiden name WAYBRIGHT, PHOEBE15. Birthplace WEST VIRGINIA

16. Informant MEMORIAL HOSPITAL  
MEMORIAL AVENUE  
 Address \_\_\_\_\_

17. Burial Date thereof 11/18/48  
 (Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Cosner CemeteryLocation Bismark W Va18. Funeral director Other ShopperAddress Blaine W Va19. Nov. 17, 1948 W. H. Tamm, M.D.

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH NOVEMBER 16, 1948 at 12:15 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 7, 1948 to Nov. 16, 1948  
 and that I last saw him 12 alive on Nov. 15, 1948

Immediate cause of death acute cholecystitis & cholelithiasis - stones in common duct  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations acute cholecystitis & cholelithiasis Date of op. Nov. 11-1948

Autopsy results Cholelithiasis & cholecystitis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE D. G. Tamm M.D. M. D. or otherAddress Medical Bldg Date signed 11-16-48

RECEIVED

NOV 23 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 110529

## 1. PLACE OF DEATH:

County AlleganyCity or town Frostburg  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? after lifeHospital, institution, or street address where death occurred:  
16 Uhl St

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Frostburg  
(If outside city or town limits, write RURAL and give nearest town)Street No. Uhl St

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Mary Barbara Mayer

## 3. (b) Social Security Number

4. Sex Female5. Color or race White6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) May 7th, 1970

6. (c) If alive, give age years

8. AGE: Years 78 Month 5 Days 28 It less than one day9. Birthplace Frostburg Md. (Allegany)

(Town, county, and state)

10. Usual occupation Retired seamstress

## 11. Industry or business

12. Name John Mayer13. Birthplace Germany14. Maiden name Elizabeth Herwig15. Birthplace Germany16. Informant Mrs. Virgil RobinsonAddress Uhl Street, Frostburg, Md.17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof 11-9-48  
(month) (day) (year)Cemetery or crematory German Lutheran CemeteryLocation Frostburg, Maryland18. Funeral director Donald HaperAddress Frostburg, Maryland19. 11-9 19. 48 Mrs. Nancy H. Rose  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 5, 1948 at 9 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1948, to November 5 1948.  
and that I last saw her alive on November 5 1948.Immediate cause of death Carcinoma of liver

DURATION

Due to Chronic nephritisDue to AtherosclerosisOther conditions X

(Include pregnancy within 3 months of death)

Major findings of operations XAutopsy results X Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

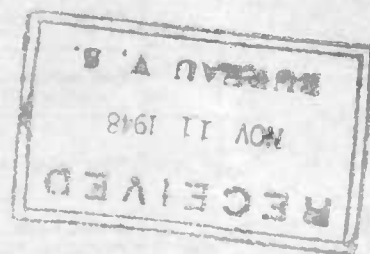
Means of injury Injured at work?

23. SIGNATURE H.C. Siehl, M.D. M. D. or otherAddress Frostburg, Md. Date signed 11/9/48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

11053

Reg. Dist. No. 1

## 1. PLACE OF DEATH:

County AlleganyCity or town Rural - Little Orleans  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Rural - Little Orleans  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Agnes Stottlemeyer Norris

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White WidowedB. (b) Name of husband or wife Charles Norris7. Birth date of deceased (mo., day, yr.) Dec 3, 1873

B. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years Months Days If less than one day  
74 11 4 \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Little Orleans, Allegany Co., Md.  
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

FATHER 12. Name Joseph Stottlemeyer13. Birthplace Allegany Co., Md.MOTHER 14. Maiden name Christina Ziegler15. Birthplace Allegany Co., Md.16. Informant Carl StottlemeyerAddress Comberland17. Burial Date thereof Nov. 11, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Patrick's CatholicLocation Little Orleans, Md.18. Funeral director Charles R. BestAddress Hancock, Md.19. Nov. 10 1948 Mrs. J. A. Watson  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 7 1948 3:45 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 28 1948 to Nov 2 1948and that I last saw her alive on Nov 2 1948

Immediate cause of death \_\_\_\_\_ DURATION \_\_\_\_\_

Cerebral hemorrhage

Due to \_\_\_\_\_

Hypertension

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Spushaffer M.D. M. D. or other \_\_\_\_\_Address Hancock Md Date signed 11/10/48



RECEIVED

NOV 15 1948

BUREAU V. P.

DR. MIRKIN

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

1860  
11054  
Reg. Dist. No.

## 1. PLACE OF DEATH:

County... ALLEGANY  
 City or town... CUMBERLAND  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?... FIVE DAYS  
 Hospital, institution, or street address where death occurred:  
MEMORIAL HOSPITAL  
 How long in hospital or institution?... FIVE DAYS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... W. VA. County... MINERAL  
 City or town... RIDGELEY  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 182 MAIN STREET  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war... ☒

## 3. (a) FULL NAME

MR. JOHN NULL

## 3. (b) Social Security Number

None

4. Sex... MALE 5. Color or race... WHITE 6. (a) Single, married, widowed, or divorced... MARRIED  
 6. (b) Name of husband or wife... EMMA BURKETT  
 7. Birth date of deceased (mo., day, yr.)... MAY 5, 1861  
 8. AGE: Years... 87 Months... 6 Days... 7 If less than one day... hrs. min.

9. Birthplace... Maryland (Town, county, and state)  
 10. Usual occupation... RETIRED  
 11. Industry or business... Brickman W.M. Ry  
 12. Name... Philip Null  
 13. Birthplace... Pennsylvania  
 14. Maiden name... Mary  
 15. Birthplace... Maryland

16. Informant... MEMORIAL HOSPITAL  
 Address... MEMORIAL AVE., CUMB., MD.  
 17. Burial Date thereof... Nov 15 '48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory... Greenmount Cem.  
 Location... Cumberland, Md.  
 18. Funeral director... Louis Stein Inc.  
 Address... Cumberland  
 19. Nov 15 1948 W.L. Frank, M.D.  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... NOVEMBER 12, 1948, at 7:05 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
 1948, to Nov 12 1948  
 and that I last saw him alive on Nov 12 1948

Immediate cause of death... Septicemia from decubitus ulcer.  
 Due to... 7 fracture left humerus.  
7 fract. l. radius & ulna.  
 Due to...  
 Other conditions... Coronary arterio-sclerosis  
 (Include pregnancy within 3 months of death)

Major findings of operations... Above  
 Date of op...  
 Autopsy results... none  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide... Acc. Date of...  
 Where did injury occur? Ridgeley W. Va.  
 (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)...  
 Means of injury Fall at home Injured at work?

23. SIGNATURE... Mirkin M. D. or other  
 Address... Cumberland Md Date signed... 11/13/48

**RECEIVED**

NOV 23 1948

**BUREAU V. S.**

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County AlleganyCity or town Cumtburland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 25 yrs

Hospital, institution, or street address where death occurred:

931 Gay St.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumtburland  
(If outside city or town limits, write RURAL and give nearest town)Street No. 931 Gay St.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Grace May Ogle

## 3. (b) Social Security Number

None4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife James T. Ogle7. Birth date of deceased (mo., day, yr.) Nov 4 18968. AGE: Years 52 Months 0 Days 1 If less than one day hrs. min.9. Birthplace Greensburg Ind.  
(Town, county, and state)10. Usual occupation Housewife11. Industry or business at Home12. Name Buhrman13. Birthplace Unknown Ind14. Maiden name Unknown

15. Birthplace

16. Informant Miss Geraldine OgleAddress Cumtburland Ind.17. Burial Date thereof Nov 8 48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Greensmough CemLocation Cumtburland18. Funeral director Louis Stein IncAddress Cumtburland19. Nov 6, 1948 W. H. Trautz, M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 5 19 48 at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 47 19 47 to Nov 5 19 48and that I last saw her alive on Oct 2 19 48Immediate cause of death metastatic Adeno carcinomaDue to Adeno carcinoma of uterus

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations Adeno carcinoma uteriDate of op. 1945

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, pub'c place (where?)

Means of injury

Injured at work?

23. SIGNATURE Arthur F. Jones M.D.Address 110 S. Centre StDate signed 11-5-48

RECEIVED

NOV 9 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 8

11056

1572

## 1. PLACE OF DEATH:

County... Allegany  
 City or town... Lonaconing  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 5 1/2 yrs - 1 mo  
 Hospital, institution, or street address where death occurred:  
East Main Street  
 How long in hospital or institution? 1

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... Maryland County... Allegany  
 City or town... Lonaconing  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No... East Main St.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war... air

## 3. (a) FULL NAME

Mary A. Peebles

## 3. (b) Social Security Number

4. Sex... Female 5. Color or race... White 6. (a) Single, married, widowed, or divorced... Single  
 6. (b) Name of husband or wife... none

7. Birth date of deceased (mo., day, yr.)... Sept 29, 1897 6. (c) If alive, give age... 1 years

8. AGE: Years... 51 Months... 1 Days... 19 If less than one day... hrs. ... min.

9. Birthplace... Lonaconing, Allegany Co., Md.  
 (Town, county and state)

10. Usual occupation... Home Work

11. Industry or business... Home

12. Name... John Peebles

13. Birthplace... Lonaconing, Md.

14. Maiden name... Mary A. Philand

15. Birthplace... Lonaconing, Md.

16. Informant... Melvin Peebles

Address... Lonaconing, Md.

17. Burial... Date thereof... Nov. 20, 1948  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory... Oak Hill Cemetery

Location... Lonaconing, Md.

18. Funeral director... Dr. Cichborn

Address... Lonaconing, Md.  
Nov 20 19 48 Jouett M. Coal  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... 11/19 1948, at 5:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/17 to 11/19 1948  
 and that I last saw her alive on 11/18 1948

Immediate cause of death... Atrophy of brain  
2 Nerve paralysis

Due to... congenital anomaly

Due to...

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations... Date of op...

Autopsy results... PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... Paul Eugene Dye, M.D.  
Lonaconing, Md. Date signed... 11/20/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 2 1948

BUREAU V. A.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County allegany  
 City or town Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 51 years  
 Hospital, institution, or street address where death occurred:  
622 Elm St  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State md County allegany  
 City or town Cumberland  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 622 Elm Street  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war

## 3. (a) FULL NAME

James Woodard Peter's  
 4. Sex m 5. Color or race w 6. (a) Single, married, widowed, or divorced married

## 3. (b) Social Security Number

None

6. (b) Name of husband or wife annie m. Peters  
 6. (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) Feb 8 - 1876

8. AGE: Years 72 Months 9 Days 7 If less than one day  
 hrs. min.

9. Birthplace Keyser W. Va.  
 (Town, county, and state)

10. Usual occupation Railroader - Retired

11. Industry or business

12. Name Peter P. Peters

13. Birthplace Romney W. Va.

14. Maiden name Katherine Davis

15. Birthplace Romney W. Va.

16. Informant Mrs. Annie M. Peters  
 Address 622 Elm St.

17. Burial Date thereof November 18, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Greenmount Cemetery

Location Cumberland, Md

18. Funeral director John J. Hoff

Address Cumberland, Md.

19. Nov. 18, 1948 Registrar W. J. Taylor

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 15, 1948 at 10:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 15, 1948 to Nov 15, 1948  
 and that I last saw him alive on Nov 15, 1948

Immediate cause of death Coronary Occlusion DURATION 1 hr.

Due to

Due to

Other conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underlie the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. J. Taylor M. D. or other

Address 1040 Locust Date signed 11/17

Please call 65 when signed.

RECEIVED

NOV 23 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

131a

11058

1. PLACE OF DEATH:

County **ALLEGANY**  
City or town **CUMBERLAND, MD.**  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? **5 DAYS**  
Hospital, institution, or street address where death occurred:  
**MEMORIAL HOSPITAL**  
How long in hospital or institution? **5 DAYS**

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State **MARYLAND** County **ALLEGANY**  
City or town **OLDTOWN**  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2.(a) If veteran, name war \_\_\_\_\_

3. (a) FULL NAME

**MR. ALBERT D. RADER**

3. (b) Social Security Number

**None**

4. Sex **MALE** 5. Color or race **WHITE** 6.(a) Single, married, widowed, or divorced **WIDOWER**  
6.(b) Name of husband or wife **ROBERTSON, GOLDIE**  
6.(c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) **APRIL 28, 1898**  
8. AGE: Years **50** Months **6** Days **8** If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace **WEST VIRGINIA**  
(Town, county, and state)  
10. Usual occupation **FARMER**  
11. Industry or business \_\_\_\_\_

**FATHER** 12. Name **SOLOMAN A. RADER**  
13. Birthplace **WEST VIRGINIA**  
**MOTHER** 14. Maiden name **MATTIE WESTFALL**  
15. Birthplace **WEST VIRGINIA**

16. Informant **MEMORIAL HOSPITAL**  
Address **MEMORIAL AVE., CITY**

17. **Burial** Date thereof **Nov. 8, 1948**  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory **Greenridge Cemetery**  
Location **near Oldtown, Md**

18. Funeral director **John J. Fisher**  
Address **Cecil, Md.**

19. **Nov. 8, 1948** Registrar **W. B. Bank, M.D.**  
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH **NOVEMBER 6, 1948** at **2:45 A.M.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **Nov 1, 1948** to **Nov 6, 1948**  
and that I last saw him alive on **Nov. 6, 1948**

Immediate cause of death **Cardiac failure**  
Due to **Cardiovascular renal disease**  
Due to **Bronchial asthma**  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE **George M. Brown** M. D. of other \_\_\_\_\_  
Address **124 Union St** Date signed **11/6/48**

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 16 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. *8*

*93d*

*11059*

### 1. PLACE OF DEATH:

County *Allegany*

City or town *Lonaconing Md.*  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Md.* County *Allegany*

City or town *Lonaconing*  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

### 3.(a) FULL NAME

*George Reidler*

### 3.(b) Social Security Number

4. Sex *Male*

5. Color of race *White*

6.(a) Single, married, widowed, or divorced *Single*

6.(b) Name of husband or wife \_\_\_\_\_

7. Birth date of deceased (mo., day, yr.) *July 3 - 1883*

8. AGE: Years *65* Months *4* Days *19* If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace *Lonaconing Md.*  
(Town, county, and state)

10. Usual occupation *Retired-Navy reserve.*

11. Industry or business \_\_\_\_\_

12. Name *Henry A. Reider*

13. Birthplace *Lonaconing Md.*

14. Maiden name *Christina Boyd*

15. Birthplace *Lonaconing Md.*

16. Informant *Mrs. William Reider*

Address *Lonaconing Md.*

17. *Burial* Date thereof *Nov 26, 1948*  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory *Oak Hill Cemetery*

Location *Lonaconing, Md.*

18. Funeral director *M. Eichhorn*

Address *Lonaconing, Md.*

19. *Nov 26* 19 *48* *Jeanette M. Boal*  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH *Nov. 22* 19 *48* at *11 A.* M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19 \_\_\_\_\_, to \_\_\_\_\_ 19 \_\_\_\_\_

and that I last saw him *Dead* *Nov. 22* 19 *48*

Immediate cause of death *Acute dilatation of the heart* at *once*  
DURATION

Due to *Chronic myocarditis and over exertion.*

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work?

Deputy Medical Examiner *Allegany*

23. SIGNATURE *H.V. Deming M.D.* *H.V. Deming M.D.*  
M. D. or other

Address *Cumberland Md.* Date signed *11-22-48*

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 2 1948

BUREAU T. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

11060

Reg. Dist. No. 5

## 1. PLACE OF DEATH:

County... AlleganyCity or town... Ancelle, near Chesapeake, Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Ancelle Celanese Corp. of Am.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... W. Va. County... MineralCity or town... Wiley Ford  
(If outside city or town limits, write RURAL and give nearest town)Street No. ....  
(If rural, give LOCATION)

2(a) If veteran, name war

## 3. (a) FULL NAME

Adam Earl Robinette

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife... Gladys Timbrook Robinette6. (c) If alive, give age... 37 years

7. Birth date of

deceased (mo., day, yr.) Dec. 30- 1904

8. AGE:

Years

Months

Days

If less than one day

43

hrs.

min.

9. Birthplace... Cumberland Md.  
(Town, county, and state)10. Usual occupation... Process worker11. Industry or business... Celanese Corp. of Am.FATHER  
MOTHER12. Name... John W. Robinette13. Birthplace... Cumberland Md.14. Maiden name... Mary Gross15. Birthplace... Cooks Mills Pa.16. Informant... wife) Gladys T. RobinetteAddress... Wiley Ford W. Va.17. Burial  
(Burial, cremation, or removal, Which?)Date thereof... Nov. 26, 1948  
(month) (day) (year)Cemetery or crematory... St. John Methodist CemLocation... Chesapeake, W. Va.18. Funeral director... James ScarpelliAddress... Cumberland Md.19. Nov. 24 19 48  
(Date rec'd by registrar)

Registrar

## 3. (b) Social Security Number

236-14-6639

## MEDICAL CERTIFICATION

20. DATE OF DEATH... Nov. 23 19 48 8:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

...19... to... 19...  
and that I last saw him Dead Nov. 23 19 48

Immediate cause of death...

(right) Coronary occlusion

DURATION

at onceDue to... arterio-coronary sclerosis

Due to...

Other conditions... Cardiac hypertrophy

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op. ....

Autopsy results... as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of ...

Where did injury occur? ...

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

Deputy Medical Examiner... Allegany Co23. SIGNATURE... H. V. Deming M.D. H. V. Deming M.D.  
M. D. otherAddress... Cumberland Md. Date signed 11.24-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

11061

93d

## 1. PLACE OF DEATH:

County AlleghenyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 40 yrs.

Hospital, institution, or street address where death occurred:

521 Arch St. Ave.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleghenyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)Street No. 521 Arch St. Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Emanuel Ross Rose

## 3. (b) Social Security Number

?

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

Mary E. Fleming

7. Birth date of deceased (mo., day, yr.)

Dec 20 1869

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

79026

hrs.

min.

9. Birthplace

Bedford Valley Pa.  
(City, county, and state)

10. Usual occupation

Self Employed - Retired

11. Industry or business

MOTHER FATHER

12. Name

George Rose

13. Birthplace

Pa.

14. Maiden name

Hannah Jane Pearson

15. Birthplace

Pa.

16. Informant

Miss Mary Etel Rose

Address

Cumberland

17.

(Burial, cremation, or removal. Which?)

Date thereof

Nov 19 48  
(month) (day) (year)

Cemetery or crematory

Sts Peter & Pauls Cmn

Location

Cumberland

18. Funeral director

Lois Stein Inc

Address

Cumberland

19.

(Date rec'd by registrar)

Nov 17 1948  
W. H. Frantz, M.D.  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov 161948at 2 45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 141946

to

Nov 161948and that I last saw him alive on Nov 13 1948

Immediate cause of death

congestive heart failure

DURATION

6 months

Due to

adventitious heart disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

C. M. Frantz, M.D.

M. D. or other

Address

59 Duane St

Date signed

11-17-48

RECEIVED

NOV 23 1948

BUREAU V. S.

*Mr. Thompson*

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County ALLEGANY  
 City or town CUMBERLAND  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 10 DAYS  
 Hospital, institution, or street address where death occurred:  
MEMORIAL HOSPITAL  
 How long in hospital or institution? 10 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY  
 City or town CUMBERLAND  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. THE DINGLE Buckingham Road  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

RICKA ROSENBAUM

## 3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

FEMALE WHITE WIDOWED6. (b) Name of husband or wife SIMON ROSENBAUM7. Birth date of deceased (mo., day, yr.) DEC. 11, 18538. AGE: Years Months Days If less than one day  
94 11 7 hrs. min.9. Birthplace Baltimore, Maryland  
(Town, county, and state)10. Usual occupation HWFE

11. Industry or business

12. Name Isaac Rosenbaum Nathan13. Birthplace Unknown14. Maiden name Carrie Stein Nathan15. Birthplace Unknown16. Informant MEMORIAL HOSPITALAddress CUMBERLAND MD17. Burial Date thereof 11-19-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory East Gate Cemetery  
Cumberland, Md.

Location

18. Funeral director John E. WolfordAddress Cumberland Md19. Nov. 19 48 W.R. Hantz, M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH NOV. 18 19 48 at 1:25 A.M.21. I CERTIFY that death occurred on the date above stated that I attended deceased from  
November 8, 1948 to November 16, 1948  
and that I last saw her alive on November 17, 1948Immediate cause of death Uremia DURATION 10 daysDue to Generalized ArteriosclerosisDue to Arteriosclerosis 14 days

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

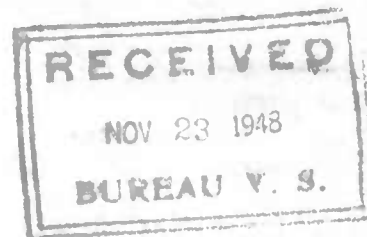
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Samuel Rosenbaum M. D. or otherAddress 50 Chesling St. Date signed 11/18/48



Within corporate limits

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County Allegany  
City or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany County Infirmary

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)Street No. 123 Oak Street  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Mahala Madeline Ryan

## 3. (b) Social Security Number

None4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed6.(b) Name of husband or wife David W. Ryan7. Birth date of deceased (mo., day, yr.) Oct. 17, 1871 6.(c) If alive, give age \_\_\_\_\_ years8. AGE: Years 77 Months 0 Days 26 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Greenridge, Md.  
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Edward Northcraft13. Birthplace Penna.14. Maiden name Mary Roby15. Birthplace Penna.16. Informant Mr. Benjamin RyanAddress 750 Maryland Ave. Cumberland, Md.17. Burial Date thereof Nov. 16, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Camp Hill Cem.Location Paw Paw, W. Va.18. Funeral director H. Wayne GeorgeAddress Cumberland, Md.19. Nov. 15 18 48 W. L. Tandy, M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13, 19 48, at 2:15 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1946 to Nov. 13 19 48  
and that I last saw h. er alive on Nov. 12 19 48Immediate cause of death Myocardial Failure DURATION 3 1/2 hrsDue to Chr. myocarditis 2 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. F. Jones M.D. M. D. or otherAddress 110 S. Centre St. Date signed 11-15-48

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NOV 23 1948

BUREAU V. S.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

11665

## I. PLACE OF DEATH:

County ALLEGANYCity or town CUMBERLAND, MD.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 daysHospital, institution, or street address where death occurred:  
MEMORIAL HospitalHow long in hospital or institution? 5 DAYS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County GARRETTCity or town OAKLAND Swallow Falls  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

OSCAR Theodore SINES Jr.

## 3. (b) Social Security Number

None4. Sex MALE 5. Color or race WHITE 6. (a) Single, married, or divorced SINGLE

6. (b) Name of husband or wife \_\_\_\_\_

7. Birth date of deceased (mo., day, yr.) NOV. 24, 19398. AGE: Years 8 Months 11 Days 106 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace MARYLAND Swallow Falls, Garrett Co.  
(Town, county, and state)10. Usual occupation Student

11. Industry or business \_\_\_\_\_

12. Name OSCAR SINES, Sr.13. Birthplace MARYLAND Swallow Falls14. Maiden name MURIEL PHILLIPPI15. Birthplace Samascus, Virginia16. Informant Oscar J. Sines, Sr.Address Swallow Falls, Md17. Burial Date thereof Nov-12-1948  
(Burial, cremation, or removal, which?) (month) (day) (year)Cemetery or crematory Henry Sines CemLocation Swallow Falls Md18. Funeral director Emory BollenAddress Oakland Md19. Nov. 12, 1948 W.R. Kautz, M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH NOVEMBER 10, 1948 at 10:45 A21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 Sept. 48 19. to 10 Nov 48 19.and that I last saw him alive on 10 Nov. 48 19.Immediate cause of death Leukemia, myeloidDURATION 8 months

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE W Alfred Van Ormer M. D. or otherAddress Cumberland, Md Date signed 12 Nov 48

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NOV 16 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County ALLEGANYCity or town CUMBERLAND, MD.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 DAYS

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITALHow long in hospital or institution? 3 DAYS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State WEST VIRGINIA County GrantCity or town CABINS, W.VA.  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3.(a) FULL NAME

BABY BOY SIONS, CREAD ERNEST

## 3.(b) Social Security Number

None

4. Sex

MALE

5. Color or race

WHITE

6.(a) Single, married, widowed, or divorced

SINGLE

6.(b) Name of husband or wife \_\_\_\_\_

7. Birth date of deceased (mo., day, yr.)

NOVEMBER 2, 1948

8. AGE: Years Months Days If less than one day

3 hrs. min.9. Birthplace CUMBERLAND, MD.  
(Town, county, and state)10. Usual occupation None

11. Industry or business \_\_\_\_\_

12. Name CREAD D. SIONS13. Birthplace WEST VIRGINIA14. Maiden name VESTA M. WOLFE15. Birthplace WEST VIRGINIA16. Informant MEMORIAL HOSPITALAddress MEMORIAL AVE., CITY17. Burial Date thereof 11/6/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Baptist CemeteryLocation West Virginia Bayard18. Funeral director Latis Steif, Inc.Address 117 Frederick St.19. Nov. 6, 48 W. R. Hodges, M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH NOVEMBER 5, 1948 at 3:30 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 2, 48 to Nov 5, 48and that I last saw him alive on Nov. 4, 1948Immediate cause of death PneumoniaDue to metastatic lesion ofbreast carcinoma.

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE W. R. Hodges, M.D.Address Cumberland, Md. Date signed 11/5/48

MARGIN RESERVED FOR BINDING

I

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 9 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. *4*

11067

## 1. PLACE OF DEATH:

County *Allegheny*  
 City or town *Cumberland*  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
*830 Buckingham Road*  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Ind* County *Allegheny*  
 City or town *Cumberland*  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. *830 Buckingham Road*  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

*Frank Ernest Smith*

## 3. (b) Social Security Number

*214-05-5169*

4. Sex *Male* 5. Color or race *White* 6.(a) Single, married, widowed, or divorced *Married*  
 6.(b) Name of husband or wife *Viola White*  
 6.(c) If alive, give age *56* years  
 7. Birth date of deceased (mo., day, yr.) *Oct 23, 1888*

8. AGE: Years *60* Months *0* Days *25* If less than one day  
 hrs. min.

9. Birthplace *Cumberland Allegheny Co., Ind*  
 (Town, county, and state)

10. Usual occupation *Bakery Owner*

11. Industry or business *Bakery*

12. Name *Philip Smith*

13. Birthplace *Germany*

14. Maiden name *Christina Mickel*

15. Birthplace *Cumberland Ind.*

16. Informant *Walter W. White*

Address *607 Fairview Ave - Cumb. Ind.*

17. *Burial* Date thereof *Nov 21, 1948*  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory *Rose Hill Mausoleum*

Location *Cumberland Ind.*

18. Funeral director *John J. Hofer*

Address *Cumberland Ind.*

19. *Nov. 20* 19 *48* *W. F. Williams, M.D.*  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH *Nov 18* 19 *48* at *4:00 P.* M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *August 10* 19 *46* to *Nov 18* 19 *48*

and that I last saw him alive on *Nov 6* 19 *48*

Immediate cause of death

*Coronary Thrombosis*

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results *None*

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Injured at work?

Means of injury

Signature *W. F. Williams* M. D. or other

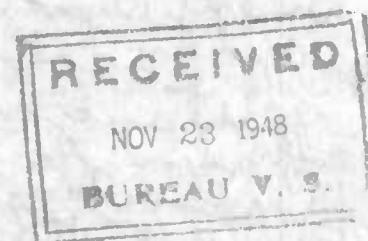
Address *Cumberland* Date signed *11/20/48*

MARGIN RESERVED FOR BINDING

VS A15

9-45-15 M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness of the certificate is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

11068

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County... Allegheny  
 City or town... Cresaptown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 16 yrs.  
 Hospital, institution, or street address where death occurred:  
Winchester Road  
 How long in hospital or institution? .....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... md County... Allegheny  
 City or town... Cresaptown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Winchester Road.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war .....

## 3. (a) FULL NAME

John Simon Staggs

## 3. (b) Social Security Number

None.

4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife... Ida Dawson  
 6. (c) If alive, give age 75 years  
 7. Birth date of deceased (mo., day, yr.) May 16 1864  
 8. AGE: Years 84 Months 5 Days 29 If less than one day  
 hrs. .... min. ....

9. Birthplace... Keyser, Mineral Co. W. Va.  
 (Town, county, and state)  
 10. Usual occupation... Farmer  
 11. Industry or business... General Farming  
 12. Name... Michael Staggs  
 13. Birthplace... Romney W. Va.  
 14. Maiden name... Sabina Hickman  
 15. Birthplace... Romney W. Va.

16. Informant... Wm. Staggs  
 Address... Cresaptown, md.  
 17. Burial Date thereof... Nov 17 1948  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory... Zion Memorial Park  
 Location... near Cumberland, md.  
 18. Funeral director... John J. Haler  
 Address... Cumberland, md.  
 19. Nov 17 1948  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... Nov 15, 1948 at 2:10 A.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Sept. 1, 1942 to Nov. 15, 1948  
 and that I last saw him alive on Nov 11, 1948

Immediate cause of death... coronary heart failure DURATION 3 months  
 Due to... arteriosclerotic heart disease 2 yrs.  
 Due to...  
 Other conditions... generalized atherosclerosis 6 yrs.  
 (include pregnancy within 3 months of death)

Major findings of operations... Date of op. ....

Autopsy results...  
 PHYSICIAN: Please notetise the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide... Date of ...  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE... L. Mingo M.D. M. D. or other  
 Address... of Sumner Date signed... 11-12-48



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JAN 7 1949

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11069

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH

County Allegheny  
 City or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 10/1/48  
 Hospital, institution, or street address where death occurred:  
Memorial Hospital  
 How long in hospital or institution? 10/1/48

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Garrett  
 City or town Rural Deer Park  
(If outside city or town limits, write RURAL and give nearest town)  
 Street No. 5 Mi So Deer Park  
(If rural, give LOCATION)  
 2. (a) If veteran, name war ✓

## 3. (a) FULL NAME

Albert Steyer

## 3. (b) Social Security Number

None

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Artie Hankin Steyer  
 6. (c) If alive, give age 47 years  
 7. Birth date of deceased (mo., day, yr.) August 12, 1880  
 8. AGE: Years 68 Months 3 Days 16 If less than one day hrs. min.

9. Birthplace Garrett Co., Md.  
(Town, county, and state)  
 10. Usual occupation Farmer  
 11. Industry or business Own Farm  
 12. Name Samuel Steyer  
 13. Birthplace Garrett Co., Md.  
 14. Maiden name Isabelle Duling  
 15. Birthplace Garrett County, Md.

16. Informant Memorial Hospital  
 Address Cumberland Md.  
 17. Burial Date there Dec. 1, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory White Church Cemetery  
 Location Garrett Co., Md.  
 18. Funeral director Arthur E. Reighton  
 Address Cumberland, Md.

19. Nov. 30, 1948 W. L. Tandy, M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28 1948 at 12:25 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 28 1948 to Nov 28 1948  
 and that I last saw him alive on Nov 28-48 1948

Immediate cause of death Peritonitis  
Ruptured gastric  
ulcer  
 Due to Peritonitis  
 Due to Ruptured gastric  
ulcer  
 Other conditions

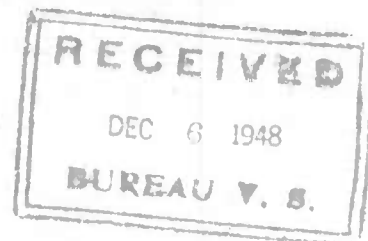
(Include pregnancy within 3 months of death)

Major findings of operations Ruptured ulcer  
& peritonitis Date of op. Nov 28

Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide None Date of Nov 28  
 Where did injury occur? None (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) None  
 Means of injury None Injured at work? None

23. SIGNATURE W. L. Tandy M. D. or other W. L. Tandy  
 Address Cumberland Date signed Nov 29



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DEC 6 1948

BUREAU V. S.

WILLIAMS corporate limited  
DR. R. WILLIAMS

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

11070

## 1. PLACE OF DEATH:

County ALLEGANY  
City or town CUMBERLAND, MD.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 269 years  
Hospital, institution, or street address where death occurred:  
MEMORIAL HOSPITAL  
How long in hospital or institution? 2 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY  
City or town CUMBERLAND  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 122 VIRGINIA AVE.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

## 3. (a) FULL NAME

MR. HARRY STORER

## 3. (b) Social Security Number

705 10 7912

4. Sex MALE 5. Color or race WHITE 6.(a) Single, married, widowed, or divorced WIDOWER  
6.(b) Name of husband or wife ANNA CORA DAVIS  
7. Birth date of deceased (mo., day, yr.) JANUARY 15, 1867  
8. AGE: Years 81 Months 00 Days 27 If less than one day  
.....hrs. ....min.

9. Birthplace ENGLAND  
(Town, county, and state)  
10. Usual occupation RETIRED  
11. Industry or business  
12. Name JAMES STORER  
13. Birthplace ENGLAND  
14. Maiden name BUTLER, ELIZABETH  
15. Birthplace England

16. Informant MEMORIAL HOSPITAL  
Address MEMORIAL AVE., CITY  
17. Burial Date thereof Nov. 14, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Rose Hill Cemetery  
Location Cumberland, Maryland  
18. Funeral director William H. Kight  
Address Cumberland, Maryland

19. Nov. 14 1948 W.R. Frank, M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH NOVEMBER 12, 1948 at 2:00A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
11/4/48 1948 to 7/12/48 1948  
and that I last saw him alive on 7/12/48 1948

Immediate cause of death

Chronic Nephritis

DURATION

2 wks

Due to

Chronic Nephritis

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Cumberland Md Date signed 11/13/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 23 1948

BUREAU T. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County Allegany  
 City or town Cumtula  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 10 days  
 Hospital, institution, or street address where death occurred: Allegany Hospital  
 How long in hospital or institution? 10 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Allegany  
 City or town Frederick  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 115 Bowery  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war

## 3. (a) FULL NAME

Mary Edith Zwigg

## 3. (b) Social Security Number

none

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Noah Zwigg  
 6. (c) If alive, give age 63 years  
 7. Birth date of deceased (mo., day, yr.) June 21-1887  
 8. AGE: Years 61 Months 4 Days 22 It less than one day hrs. min.

9. Birthplace California, Washington, Pa.  
 (Town, county, and state)

10. Usual occupation housewife

11. Industry or business house

12. Name Dr. Daniel Sims

13. Birthplace France

14. Maiden name unknown

15. Birthplace

16. Informant Mrs. Mary Mc Gregor

Address Frederick, Md.

17. Burial Date thereof Nov. 15, 1948  
 (Burial, cremation, or removal. Which) (month) (day) (year)

Cemetery or crematory Allegany

Location Frederick, Md.

18. Funeral director J. R. Stuart

Address Frederick, Md.

19. Nov. 14, 1948 W. H. Brantz, M.D.  
 (Date rec'd by Registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 13, 1948 at 4:48 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 3, 1948 to November 13, 1948

and that I last saw him alive on November 12, 1948

Immediate cause of death bronchopneumonia

carcinoma

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. Brantz, M.D.

Address 59 S. Green St. Date signed 11-13-48

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NOV 23 1948

BUREAU V. S.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County AlleganyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

859 Camden Ave.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)Street No. 859 Camden Ave.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Annie L. Wolfe

## 3. (b) Social Security Number

None

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Widowed6.(b) Name of husband or wife Charles A. Wolfe7. Birth date of deceased (mo., day, yr.) July 30, 1866 6.(c) If alive, give age years8. AGE: Years 82 Months 3 Days 8 If less than one day  
.....hrs. ....min.9. Birthplace Cumberland, Md.  
(Town, county, and state)10. Usual occupation Housewife

## 11. Industry or business

12. Name Charles Ridgely13. Birthplace Unknown14. Maiden name Elizabeth Thresher15. Birthplace Unknown16. Informant Mrs. W. Carl RichardsAddress 859 Camden Ave. Cumberland, Md.17. Burial Date thereof Nov. 10, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill Cem.Location Cumberland, Md.18. Funeral director Charles L. GeorgeAddress Cumberland, Md.19. Nov. 10, 1948 W. R. Tautz, M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8, 194821. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Jan 10, 1948 to Nov 8, 1948  
and that I last saw him alive on 11/8/48Immediate cause of death Myocardial InfarctionDue to Arteriosclerotic C.V.D. & Cerebral Hemorrhage

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE W. R. Tautz, M.D. M.D. or otherAddress Cumberland Date signed 11/8/48

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NOV 16 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 1310 11073 4

## 1. PLACE OF DEATH:

County ALLEGANYCity or town CUMBERLAND  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? TWO DAYS

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITALHow long in hospital or institution? TWO DAYS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANYCity or town CUMBERLAND LUKE  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_

(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

MRS. ISABELLA WORGAN

## 3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

FEMALEWHITEMARRIED6. (b) Name of husband or wife HUBERT WORGAN7. Birth date of deceased (mo., day, yr.) APRIL 19, 18776. (c) If alive, give age 75 years8. AGE: Years Months Days If less than one day  
71 6 23 hrs. min.9. Birthplace MARYLAND  
(Town, county, and state)10. Usual occupation HOUSEWIFE

11. Industry or business \_\_\_\_\_

12. Name JAMES NELSON13. Birthplace MARYLAND14. Maiden name FLORA SINCLAIR15. Birthplace MARYLAND16. Informant MEMORIAL HOSPITALAddress MEMORIAL AVE., CUMB., MD.17. Burial Date thereof Nov. 15, 1948  
(Burial, cremation, or removal) (month) (day) (year)Cemetery or crematory Philas CemLocation Westernport, Md.18. Funeral director Ellsworth S. BorkAddress Westernport, Md.19. Nov. 15 19 48 W.R. Bork, M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH NOVEMBER 12, 1948 at 6:45p PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 10 19 48 to Nov. 12 19 48and that I last saw him alive on Nov. 12 19 48

Immediate cause of death \_\_\_\_\_ DURATION \_\_\_\_\_

Cardiac Vascular  
Renal DiseaseDue to Hypertensive heartDue to DiseaseOther conditions Primary Anemia

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. \_\_\_\_\_

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Wm. F. Williams  
M, D, or other \_\_\_\_\_Address Cumberland Date signed 11/15/48

**RECEIVED**

NOV 23 1948

**BUREAU V. S.**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

11074

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County ALLEGANY  
 City or town CUMBERLAND, MARYLAND  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 81 years  
 Hospital, institution, or street address where death occurred:  
MEMORIAL  
 How long in hospital or institution? 1 DAY

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY  
 City or town CUMBERLAND  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 404 MARYLAND AVE.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

CLARA YERGAN

## 3. (b) Social Security Number

None

4. Sex FEMALE 5. Color or race WHITE 6.(a) Single, married, widowed, or divorced WIDOWED  
 6.(b) Name of husband or wife FREDERICK YERGAN  
 7. Birth date of deceased (mo., day, yr.) 2/5 1867  
 8. AGE: Year 81 Months 9 Days 4 If less than one day  
hrs. min.

9. Birthplace Cumberland, Allegany, Maryland  
 (Town, county, and state)  
 10. Usual occupation Housewife  
 11. Industry or business

12. Name GEORGE W. MARVIN  
 13. Birthplace Dabbury, Conn.  
 14. Maiden name SARAH Willison  
 15. Birthplace Cumberland, Maryland

16. Informant MEMORIAL HOSPITAL  
CUMBERLAND, MD.  
 Address

17. Burial Date thereof Nov. 12, 1948  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Rose Hill Cemetery  
 Location Cumberland, Md.

18. Funeral director William H. Kight  
 Address Cumberland, Maryland

19. Nov. 12, 1948 W. L. Tandy, M.D.  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 11/9/48 19 9:45 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/8/48 19, to 11/9/48 19, and that I last saw him alive on 11/9/48 19.

Immediate cause of death Coronary Occlusion DURATION

Due to

Due to

Other conditions Diabetes

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

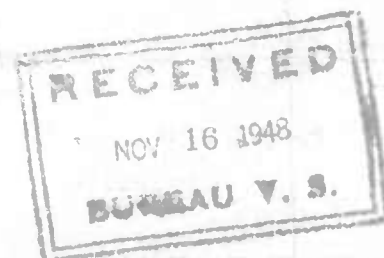
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury Injured at work?

23. SIGNATURE George M. Marvin M. D. or other

Address 128 Union St Date signed 11/9/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY  
City or town CUMBERLAND, MARYLAND  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 3 days  
Hospital, institution, or street address where death occurred MEMORIAL Hospital  
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County GARRETT  
City or town GRANTSVILLE  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2.(a) If veteran, name war \_\_\_\_\_

3. (a) FULL NAME

EDWARD M. YODER

3. (b) Social Security Number

None

4. Sex MALE 5. Color or race WHITE 6.(a) Single, married, widowed, or divorced MARRIED  
6.(b) Name of husband or wife ANNA E. BEACHY  
7. Birth date of deceased (mo., day, yr.) AUG. 7, 1878  
6.(c) If alive, give age 69 years  
8. AGE: Years 70 Months 3 Days 8 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace MARYLAND, near Grantsville  
(Town, county, and state)  
10. Usual occupation Farmer  
11. Industry or business Farming  
12. Name MOSES E. YODER  
13. Birthplace PENNA.  
14. Maiden name CAROLINE BEACHY  
15. Birthplace MD.

16. Informant MEMORIAL HOSPITAL  
Address CUMBERLAND, MD.

17. Burial Date thereof Nov. 18, 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Amial  
Location Grantsville, Md.

18. Funeral director William Wintuberg  
Address Grantsville, Maryland

19. Nov. 17, 1948 W. L. Frank, M.D.  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV. 15, 1948 at 1:30 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-14- 1948 to 11-15- 1948  
and that I last saw him alive on 11-15- 1948

Immediate cause of death \_\_\_\_\_ DURATION \_\_\_\_\_

Periculous Anemia  
Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Chronic nephritis  
Arteriosclerosis  
(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Autopsy results Periculous anemia, chronic nephritis  
PHYSICIAN: Please underline the cause to which death is attributed Arteriosclerosis

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Howard P. Tolson M. D. or other \_\_\_\_\_

Address Cumberland, Md. Date signed 11-16-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

NOV 23 1948

BUREAU V. S.